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Sharia-Integrated Healthcare: A Comprehensive Analysis of Islamic Hospitals' Preparedness for the KRIS Policy in Indonesia

Atención a la salud integrada con la *sharia*: un análisis exhaustivo de la preparación de los hospitales islámicos para la política KRIS en Indonesia

Yudi Adnan. Public Health Department, Universitas Islam Negeri Alauddin Makassar, Indonesia.
Email: yudi.adnan@uin-alauddin.ac.id https://orcid.org/0000-0001-6082-5918
Surahmawati. Public Health Department, Universitas Islam Negeri Alauddin Makassar, Indonesia.
Email: surahmawati@uin-alauddin.ac.id, https://orcid.org/0009-0002-1576-5113
Miftahul Jannah. Public Health Department, Universitas Islam Negeri Alauddin Makassar, Indonesia.
Email: miftahul.jannah@uin-alauddin.ac.id, https://orcid.org/0000-0002-1730-6407

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Abstract

The Standardized Inpatient Class (KRIS) policy aims to improve healthcare quality and equity in Indonesia, specifically supporting the National Health Insurance (JKN) program. This study evaluates the readiness of Islamic hospitals and the sharia healthcare ecosystem for KRIS implementation. Through a mixed-methods approach involving 29 hospitals, the study assessed readiness based on 12 KRIS criteria, including infrastructure, medical facilities, and the integration of sharia principles. Findings show significant progress in physical facility standards; however, challenges remain regarding limited inpatient capacity and insufficient isolation and ICU spaces. While sharia-compliant features—such as *wudhu* facilities and halal materials—are largely implemented, improvements in spiritual services are needed. Furthermore, regulatory uncertainties regarding tariff adjustments and human resource constraints in remote areas pose additional hurdles. The study recommends enhanced government support, policy harmonization, and specialized training to ensure successful KRIS implementation.

Keywords: Infrastructure Readiness, Islamic Hospitals, Standardized Inpatient Class (KRIS), Sharia Healthcare Industry, National Health Insurance (JKN), Health Policy, Indonesia

Resumen

La política de Clasificación Estandarizada de Pacientes Hospitalizados (KRIS, por sus siglas en *bahasa* indonesia) tiene como objetivo mejorar la calidad y la equidad de la atención médica en Indonesia, apoyando específicamente el programa del Seguro Nacional de Salud (JKN, por sus siglas en *bahasa*). Este estudio evalúa la preparación de los hospitales islámicos y el ecosistema de atención médica basado en la *sharia* para la implementación de la KRIS. Mediante un enfoque de métodos mixtos que involucró a 29 hospitales, el estudio evaluó la preparación con base en 12 criterios, incluyendo infraestructura, instalaciones médicas y la integración de los principios sharia. Los hallazgos muestran un progreso significativo en los estándares de las instalaciones físicas; sin embargo, persisten desafíos con respecto a la capacidad limitada de hospitalización y la insuficiencia de espacios de aislamiento y UCI. Si bien las características que cumplen con la *sharia*, como las instalaciones *para el wudu* y los materiales halal, están ampliamente implementadas, se necesitan mejoras en los servicios espirituales. Además, las incertidumbres regulatorias con respecto a los ajustes de tarifas y las limitaciones de recursos humanos en áreas remotas plantean obstáculos adicionales. El estudio recomienda un mayor apoyo gubernamental, la armonización de políticas y capacitación especializada para garantizar una implementación exitosa de la KRIS.

Palabras clave: Preparación de la infraestructura, hospitales islámicos, clasificación estandarizada de pacientes hospitalizados (KRIS), industria de la salud islámica (Sharia), seguro nacional de salud (JKN), política de salud, Indonesia

Introduction

Globally, healthcare systems struggle to balance quality, access, and efficiency. Studies frequently highlight trade-offs between these dimensions, particularly in low- and middle-income countries where resource scarcity and inefficient allocation hinder progress [1, 2] Frameworks such as the "Pathway to High Effective Coverage" emphasize coordinated actions to enhance service delivery; however, significant gaps in care persist, underscoring the need for better evidence to achieve Universal Health Coverage (UHC) [3, 4, 5]

In Indonesia, the push toward UHC via the National Health Insurance (*Jaminan Kesehatan Nasional*; JKN) program represents a major policy effort to achieve equity in access. A central initiative within this framework is the implementation of the Standardized Inpatient Class (*Kelas Rawat Inap Standar*; KRIS), which aims to provide uniform medical and non-medical benefits to all JKN participants, regardless of their socioeconomic status [6, 7]

Despite its potential to reduce inequalities, the implementation of KRIS faces significant hurdles [8, 9, 10, 11] These include infrastructure disparities, inadequate hospital bed capacity, and the substantial renovation costs required to meet new standards [12, 13] Islamic Hospitals (*Rumah Sakit Islam*; RSI), which integrate religious principles into their service delivery, encounter unique challenges in aligning KRIS standards with their organizational values and identity [14] Consequently, evaluating RSI readiness is essential to ensure effective KRIS implementation without compromising their distinct service orientation.

Previous studies emphasize the importance of robust infrastructure in delivering high-quality healthcare; for instance, resilient infrastructure is linked to enhanced service capacity and operational flexibility [15] Adopting Total Quality Management (TQM) or Continuous Quality Improvement (CQI) has significantly improved hospital service delivery in countries like Thailand and India .16 Similarly, Indonesia has seen progress, with 62.7% of hospitals reportedly complying with credentialing standards set by BPJS Kesehatan (the national health social security agency) and the latest accreditation guidelines from KARS (the Hospital Accreditation Commission) [17]

However, a notable gap remains in the literature concerning the readiness of hospitals grounded in religious values, particularly Islamic Hospitals in Indonesia. Studies exploring the integration of Islamic principles—such as providing halal food, adequate prayer facilities, and ethical patient-provider interactions—remain **limited**. Furthermore, the roadmap outlined by BPJS Kesehatan for KRIS implementation by 2025–2026 highlights critical challenges, including the standardization of inpatient rooms, financial constraints, and the integration of value-based healthcare [18] Addressing these gaps is essential for ensuring inclusive and culturally sensitive healthcare reforms.

This study aims to evaluate the readiness of Islamic Hospitals in Indonesia to implement the KRIS policy, focusing on infrastructure, management, and the integration of Islamic values in inpatient services. By examining physical infrastructure, religious principles, and organizational preparedness within the broader Islamic healthcare ecosystem, this research seeks to provide actionable insights that align religious values with national standards. These findings are expected to contribute to the policy-making process, offering perspectives on how religiously oriented institutions can adapt to evolving demands while maintaining their unique identity.

Method

This study **employed** a mixed-methods approach, combining quantitative and qualitative methodologies. The quantitative component measured the readiness of Islamic hospitals to meet the Standardized Inpatient Class (KRIS) requirements under Government Regulation No. 47 of 2021. Meanwhile, the qualitative aspect explored challenges and opportunities in KRIS implementation, particularly regarding the integration of Islamic principles. This dual approach provided a holistic understanding, combining measurable data with in-depth contextual insights [19, 20]

The research was conducted over six months (July–December) across 29 Sharia-certified Islamic Hospitals in partnership with BPJS Kesehatan. The sample was selected via purposive sampling to ensure a diverse representation of hospital characteristics, including ownership status (public vs. private), hospital type (A, B, or C), and inpatient facility capacity .[21] The final sample included one type C RSI, 16 type A, and 12 type B institutions. In-depth interviews were conducted with representatives from RS Annisa, Muhammadiyah, and Nahdlatul Ulama, supplemented by direct observations at RS Tajuddin Khalid. Data were gathered through structured questionnaires, interviews, observations, and document reviews. The primary questionnaire, based on the 12 KRIS criteria, evaluated physical factors—such as room dimensions, bed spacing, ventilation, and lighting—alongside sharia-specific service facilities.

Hospital infrastructure variables were evaluated using a percentage scale to determine overall readiness. This scale categorized readiness into five levels: highly qualified (> 80%), qualified (60–79%), moderately qualified (40–59%), not yet qualified (20–39%), and non-qualified (< 20%).[22] Based on the consensus for the 12 KRIS-JKN criteria, readiness was further segmented into four performance brackets: below 60%, 60–70%, 71–90%, and above 90%. These benchmarks were also applied to the evaluation of Sharia-integrated elements within the KRIS framework .[22, 23]

Quantitative data were analyzed via descriptive statistics using SPSS, while qualitative data were processed thematically according to Van Meter and Van Horn's policy implementation framework. Validity was established through expert consultation and triangulation, and reliability was confirmed using Cronbach's Alpha. Qualitative insights were gathered from key informants, including hospital directors and technical staff, while direct observations validated physical and operational readiness. These primary data sources were supplemented by secondary data, including hospital self-assessments and service statistics.

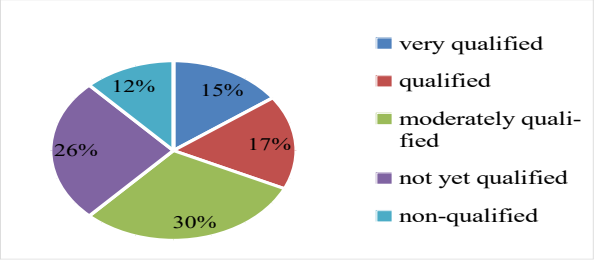
Ethical Approval

The National Ethics Committee approved the 2018 Basic Health Research in Indonesia (LB.02.01/2/KE.024/2018). The survey removed all respondents' identities from the dataset. Respondents have provided written consent for their participation in the study.

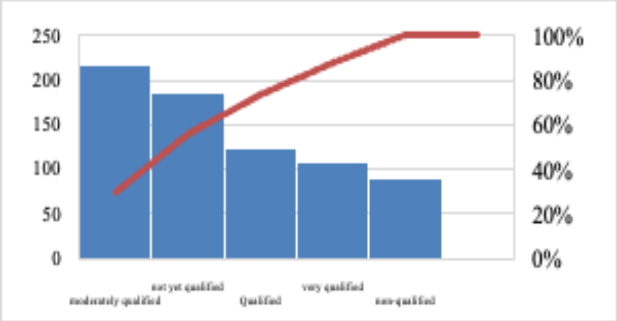
Result

Quantitative descriptive data are presented visually in Figure 1 to illustrate patterns in hospital infrastructure readiness. Overall, the findings indicate varying levels of preparedness among RSIs regarding the KRIS policy. Specifically, 15% of respondents were classified as highly qualified (> 80% readiness), while 17% were qualified (60–79%). The largest group of hospitals, at 30%, was moderately qualified (40–59%). Meanwhile, 26% were categorized as not yet qualified (20–39%), and the remaining 12% were non-qualified (< 20%).

Figure 1. RSI Infrastructure Readiness Level Diagram



Additionally, Figure 2 presents a histogram illustrating the readiness levels of RSI infrastructure across these five categories. The data reveal that the "moderately qualified" category dominates with the highest count, followed by the "not yet qualified" category. This indicates that a significant number of RSIs have achieved a moderate level of infrastructure readiness. However, the number of RSIs decreases in the qualified, very qualified, and non-qualified categories, with the non-qualified group recording the lowest count.



The survey results in Table 1 reveal significant variations in the readiness of hospital infrastructure to meet the 12 KRIS-JKN criteria as of October 2024. At a readiness level below 60%, the room area per bed met only 53% of the standard, while the distance between bed edges (>1.5 m) reached 55%. This indicates limitations in space allocation, which could affect patient comfort and privacy.

A readiness level of 60–70% was achieved for three criteria: the maximum number of beds per room (70%), low building porosity (65%), and partitions between beds made of non-porous materials equipped with ceiling-mounted rails (70%). Although these criteria met the minimum standards, improvements in design and material quality are still needed to enhance effectiveness and quality.

At the 71–90% readiness level, significant progress was observed in hospital facilities, including in-room bathrooms meeting five standards (80%), bed amenities fulfilling three standards (80%), adequate ventilation (75%), and the presence of one bedside cabinet per bed (75%). This reflects a growing awareness among hospitals regarding the importance of patient comfort and hygiene, though disparities among facilities require further attention. Meanwhile, a readiness level above 90% was achieved for two criteria: maintaining room temperature between 20–26°C (95%) and optimal room lighting (95%). These achievements demonstrate the successful implementation of physical environmental standards to support patient well-being.

The survey results in Table 2 regarding the integration of Sharia elements in KRIS show variations in the readiness levels of facilities, with most variables indicating positive progress. Moderate readiness (60–70%) was observed for the integration of nurse call systems with spiritual or religious guidance services as needed (65%). High readiness (71–80%) was achieved for bathrooms equipped with facilities for performing ablution (*wudu*) according to Islamic teachings (80%), as well as for ventilation systems that support patient comfort while maintaining privacy in accordance with Sharia principles (80%).

Very high readiness levels (>90%) were reported for several critical variables, including: adequate lighting to support patient worship activities (90%), building materials free of *haram* (prohibited) substances (90%), room division by gender, age, and disease type (95%), and rooms equipped with *Qibla* indicators (100%). These findings reflect strong progress in aligning hospital facilities with Sharia-based healthcare standards.

Table 1 Summary of KRIS readiness survey results based on the consensus of the 12 KRIS JKN criteria in October 2024

Readiness Level	Variable
< 60%	Room area per bed (53%)
	Distance between bed edges ≥ 1.5 m² (55%)
60–70%	Maximum number of beds per room (70%)
	Buildings with low porosity (65%)
	Partitions between beds with embedded ceiling rails and non-porous materials (70%)
71–90%	In-room bathrooms meet 5 standards (80%)
	Bed amenities meet 3 standards (80%)
	Ventilation (75%)
	One bedside cabinet per bed (75%)
> 90%	Room temperature 20–26°C (95%)
	Room lighting (95%)

Table 2 Summary of survey results on the integration of Sharia elements in KRIS readiness according to the 12 KRIS JKN criteria consensus in October 2024

Readiness Level	Variable
60–70%	Integrated nurse call system with spiritual or religious guidance services as needed (65%)
71–80%	Bathrooms equipped with facilities for performing ablution (*wudu*) and hygiene according to Islamic teachings (80%)
	Ventilation supports patient comfort in accordance with Sharia principles, maintaining privacy and cleanliness without disrupting worship (80%)
> 90%	Adequate lighting to support patient worship activities (80%)
	Building materials do not contain haram substances (90%)
	Rooms are equipped with *Qibla* indicators (100%)
	Room division by gender, age, disease type (infection, non-infection, childbirth) (95%)

Discussion

The findings in Figure 1 highlight a critical need for improvement in hospital infrastructure to effectively implement health policies like KRIS. Similar studies in Uganda and Kenya have shown that many health facilities struggle with readiness, particularly in managing non-communicable diseases and responding to COVID-19, indicating a broader systemic issue in healthcare preparedness [24, 25]

The cumulative line in red (Figure 2) adds further perspective, showing that approximately 80% of total infrastructure readiness is concentrated in the two most prevalent categories: moderately qualified and not yet qualified. The findings align with broader challenges in health systems, such as inadequate infrastructure and workforce issues, particularly in low- and middle-income countries[24, 26, 27] This suggests that while most RSIs have achieved a commendable level of readiness, there remains a noticeable gap in the other categories, such as the qualified, very qualified, and especially the non-qualified groups.

From a practical standpoint, this distribution highlights significant potential among RSIs with higher readiness levels while emphasizing the need for greater attention to those in the lower categories. To improve overall infrastructure readiness, targeted strategies are essential, including enhancements in physical facilities, staff training, and the development of information technology—particularly for RSIs currently in the qualified, very qualified, and non-qualified categories [28]

Regarding the data in Table 1, challenges in meeting hospital design standards—particularly concerning room area per bed and bed spacing—often arise from land constraints and outdated building designs, which can hinder patient comfort and safety [39, 40] Renovation efforts and new construction with improved planning are essential, alongside strategic interventions such as using durable materials that comply with regulations and implementing evidence-based strategies, such as single-patient rooms, to enhance patient outcomes and reduce infections [41, 42] While progress has been noted in in-room bathrooms, ventilation, and furniture, moderate readiness levels in areas such as partition material quality and the maximum number of beds per room highlight opportunities for improvement. Variability in readiness across hospitals underscores the need for tailored solutions and further analysis to identify factors driving or inhibiting effective design implementations [43]

High readiness levels in maintaining room temperature and lighting reflect the effective implementation of technology and environmental control systems, which are essential for creating a safe, comfortable care environment and preventing nosocomial infections [44] Improved ventilation, staff training on infection prevention and control (IPC), adherence to hygiene protocols, and strategic budget allocations for infrastructure upgrades—including disaster risk management and infection-control designs—are critical to meeting KRIS JKN standards [45, 46, 47] While advancements have been made, particularly in environmental controls, hospitals in developing

regions still face challenges in securing the resources necessary for comprehensive implementation. This study highlights the need for an integrated strategy involving training, incentives, and targeted investments by governments and hospital management to accelerate compliance with KRIS JKN standards.

The survey findings from Table 2 demonstrate significant advancements in integrating Sharia principles into hospital facilities, particularly in areas with very high readiness, such as Qibla indicators and gender-based room division. These achievements underscore the prioritization of Islamic values in healthcare infrastructure planning and design, aligning with the KRIS JKN framework. High readiness levels in bathrooms equipped for ablution and Sharia-compliant ventilation systems indicate substantial efforts in incorporating Islamic teachings into daily patient care. These features are critical for maintaining dignity, privacy, and spiritual well-being, particularly during extended hospital stays.

Despite these advancements, moderate readiness in integrating nurse call systems with spiritual or religious guidance services highlights areas for improvement. This integration is essential for providing holistic care that addresses both physical and spiritual needs. Investments in technology upgrades and collaboration with spiritual care providers could enhance readiness in this area, ensuring more comprehensive support for patients.

The very high readiness levels in building materials, lighting, and Qibla indicators reflect compliance with Sharia principles and highlight a robust commitment to fostering a supportive environment for Muslim patients. However, variations across hospitals suggest the need for tailored strategies to address resource disparities and ensure consistent implementation of Sharia-compliant features nationwide. The integration of Sharia elements in KRIS reflects a growing trend in healthcare that emphasizes holistic care and patient-centered services. Research indicates significant progress in cleanliness, comfort, and addressing spiritual needs, which are crucial for patient satisfaction [48, 49, 50] The application of Sharia principles has been linked to improved patient satisfaction, fostering loyalty and positive word-of-mouth among patients [48, 51]

However, challenges remain in fully implementing Sharia principles. Creating a conducive atmosphere for patient satisfaction requires continuous evaluation and adaptation to align services with Sharia standards effectively [48, 49] Resistance may also arise from patients prioritizing medical outcomes over spiritual considerations, underscoring the importance of a balanced approach to healthcare delivery [50]

Future research should explore the impact of Sharia integration on patient satisfaction and health outcomes, addressing barriers to achieving readiness in facilities with moderate performance. Assessing the cost-effectiveness and scalability of these interventions will provide valuable insights to guide policy and investment decisions. These findings contribute to the growing body of literature on culturally sensitive healthcare and its role in enhancing patient-centered care.

Based on the in-depth interviews, the KRIS policy—supported by a strong legal foundation such as Government Regulation No. 47 of 2021—aims to enhance access and efficiency in healthcare through standardized tariffs and services. However, its implementation faces significant challenges, including inconsistent regulations, stagnant tariffs, and ambiguity in participant segmentation. Regulatory inconsistencies, such as frequent changes, create confusion among healthcare providers, while the unchanged INA-CBG tariffs since 2016 limit hospitals' financial viability [52, 53] Furthermore, unclear participant segmentation complicates service delivery and reimbursement processes, particularly for private hospitals [52]

Resource constraints exacerbate these challenges, especially in government and rural hospitals. Limited operational budgets restrict hospitals' ability to expand services, while a shortage of qualified medical personnel hampers service delivery, particularly in underserved areas [54] Infrastructure limitations, such as insufficient room capacity for PBI (subsidized) patients, further hinder effective implementation, particularly in remote regions [53] These resource-

related barriers highlight the need for enhanced investments and equitable resource distribution to ensure successful policy execution.

Efforts by the Indonesian Hospital Association (PERSI) have improved policy understanding among implementers, yet differences in interpretation across hospitals persist due to frequent regulatory changes [52] The development of Standard Operating Procedures (SOPs) and support from religious organizations like Muhammadiyah and Nahdlatul Ulama, as well as the Ministry of Religious Affairs, strengthen implementation efforts. However, uneven supervision and training create gaps in ensuring uniform application of the policy [53] Despite these challenges, the general sentiment among implementers is supportive of the policy, though private hospitals remain skeptical due to cost and operational concerns.

The KRIS policy represents a significant step toward improving healthcare access and standardization in Indonesia. However, addressing regulatory inconsistencies, updating tariffs, clarifying participant segmentation, and mitigating resource constraints are essential for its successful implementation. Enhanced supervision, consistent training, and collaborative efforts with stakeholders can bridge existing gaps, fostering a more efficient and equitable healthcare system.

Conclusion

The implementation of the Standardized Inpatient Class (KRIS) policy within an Integrated Sharia Inpatient Room framework holds significant potential for improving the quality of hospital services. However, it faces various challenges, particularly related to resource limitations, infrastructure constraints, and unclear regulations that hinder hospital planning and strategic development. While some hospitals have made notable progress in meeting KRIS standards, there is an urgent need to enhance room capacity, provide full-time medical staff, and integrate technology to better support spiritual care services. Government support through clear policies, adequate funding, and strengthened medical staff training, as well as systematic improvements to hospital infrastructure, is essential to ensure the successful and sustainable implementation of KRIS.

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