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The Relationship Between The Implementation Of Standard Inpatient Care (Kris) And Service Quality On Patient Satisfaction At Raa Soewondo Pati Regional General Hospital

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Abstract

Improving equitable inpatient service quality remains a critical challenge in Indonesia following the implementation of the Standard Inpatient Care Class policy. This study examined the relationship between policy implementation, service quality dimensions, and patient satisfaction at RAA Soewondo Pati Regional Hospital. A quantitative cross-sectional design was employed involving 150 inpatients selected through simple random sampling from a population of 235 standard-class patients. Data were collected using a structured SERVQUAL questionnaire covering reliability, responsiveness, assurance, empathy, tangibles, and overall satisfaction. Descriptive statistics, Chi-square tests, and Spearman rank correlation were applied. Results showed that most respondents rated service quality positively: reliability (90.0%), responsiveness (91.3%), assurance (80.7%), empathy (85.3%), and tangibles (79.3%). Overall, 87.3% of patients reported satisfaction. Chi-square analysis indicated that only age was significantly associated with satisfaction ($p < 0.001$). Spearman analysis confirmed a positive correlation between age and satisfaction ($rs = 0.233$; $p = 0.004$) and between tangibles and satisfaction ($rs = 0.201$; $p = 0.014$). Reliability, responsiveness, assurance, empathy, and gender were not significantly related to satisfaction ($p > 0.05$). The findings suggest that the policy has effectively improved structural and physical aspects of care, while interpersonal service dimensions remain relatively uniform. Hospitals should prioritize facility enhancement alongside communication and empathy training to further improve patient satisfaction.

Keywords: Health Service Quality, Inpatient Care, Patient Satisfaction, SERVQUAL, Standard Inpatient Care Class.

INTRODUCTION

Improving the quality of healthcare services has become a global priority, in line with the commitment to equal access to basic health care for all levels of society (World Health Organization, 2023; Dreiher et al., 2020). The Universal Health Coverage (UHC) report for 2025 indicates that only 585 million people worldwide will be able to access essential services without financial barriers, indicating a persistent disparity in access (World Health Organization, 2025). At the national level, Indonesia has launched the National Health Insurance (JKN) through BPJS Kesehatan (Social Security Agency for Health) since 2014, making it one of the largest single-payer schemes in the world (Saputro & Fathiyah, 2022). However, a major challenge lies in the disparity in service quality between JKN and non-JKN patients, with a literature review revealing that 60% of studies found this inequity (Sumadi et al., 2022; Sari et al., 2023). The relevance of this topic is not only scientific, enriching health management studies, but also practical in supporting the achievement of sustainable UHC.

Narrowing the context to Indonesia highlights the Standard Inpatient Class (KRIS) policy as a government response to this disparity, as stipulated in the Decree of the Director General of Health Services Number HK.02.02/I/1811/2022 and Presidential Regulation Number 59 of 2024 (Presidential Regulation of the Republic of Indonesia Number 59 of 2024; Astuti et al., 2025). This policy requires a minimum of 60% of beds in government hospitals to be allocated to the standard class with 12 integrated criteria, including patient safety and infection control (Hartono et al., 2025). Empirical data from RSUD RAA Soewondo Pati shows that patient satisfaction in the second quarter of 2024 reached 84.42%, up from 84.28% in 2023, although still below the Ministry of Health standard (≥95%) (Pamungkas et al., 2023). In addition, the Bed Occupancy Rate (BOR) fluctuated from 91.44% (January) to 64.43% (September 2024) reflecting operational instability post-KRIS implementation (Nyoman Dharma Wiasa et al., 2025; Pratiwi & Santoso, 2024).

Previous studies confirmed that KRIS implementation has the potential to improve service quality through managerial planning, organization, and control (Valiotis et al., 2025; Farid & Larasati, 2025). Pamungkas et al.'s (2023) study in Central Java hospitals found a 15% increase in JKN patient satisfaction post-KRIS, while Nyoman Dharma Wiasa et al. (2025) reported a positive correlation between KRIS infrastructure and the service tangibility dimension. These findings align with the SERVQUAL framework, where service quality is a key predictor of satisfaction (Nampewo et al., 2022; Mey Lona Verawaty Zendrato, 2022).

However, research findings show inconsistencies; for example, Sumadi et al. (2022) identified dissatisfaction with the empathy and responsiveness dimensions despite high BOR, while Astuti et al. (2025) found a contradiction in private hospitals where KRIS actually reduced efficiency due to limited human resources. Methodological limitations in these studies include a cross-sectional approach without longitudinal analysis, a sample size limited to a single region, and minimal integration of managerial variables such as supervision and patient participation (Hartono et al., 2025; Sari et al., 2023).

A significant research gap lies in the lack of empirical studies examining the causal relationship between KRIS implementation, service quality, and patient satisfaction in regional hospitals post-2024, particularly with fluctuating BOR and dissatisfaction below national standards. This problem statement emphasizes that although KRIS was designed to eliminate discrimination, field evidence at RSUD RAA Soewondo Pati shows a gap between policy and reality, with satisfaction suboptimal and BOR unstable (Saputro & Fathiyah, 2022; Pratiwi & Santoso, 2024).

This study aims to analyze the relationship between KRIS implementation and service quality on patient satisfaction at RAA Soewondo Pati Regional Hospital, with the specific objective of empirically exploring the SERVQUAL dimension. The urgency of this study is driven by the momentum following the implementation of KRIS by the end of 2024 and the 2026 UHC target. The novelty lies in the longitudinal mixed-method approach that integrates real-time BOR data—different from previous descriptive studies. The theoretical contribution enriches the policy-based health management model, while the practical contribution provides recommendations for hospital management and policymakers to optimize KRIS for equitable service distribution.

RESEARCH METHODS

This study employed a quantitative approach with a cross-sectional design to measure the relationship between the implementation of the Standard Inpatient Class (KRIS), service quality, and patient satisfaction using a snapshot approach over a specific period (Sugiyono, 2023; Sudaryono, 2022). This design was chosen because it allows for primary data collection through a survey that is efficient, objective, and generalizable to the target population, as recommended in similar health studies (Subhaktiyasa, 2024; Pratiwi & Santoso, 2024). This approach aligns with the SERVQUAL framework for exploring patient perceptions, where data are collected simultaneously to test causal hypotheses without longitudinal intervention (Emzir, 2021; Sari et al., 2023).

The study population included all standard class inpatients at RAA Soewondo Pati Regional Hospital during the study period, totaling 235 people based on 2025 medical records (Pamungkas et al., 2023). The sample was determined using the Slovin formula with a margin of error of 5% (e=0.05), resulting in a minimum sample size of 144 respondents rounded to 150 to anticipate a non-response rate of 10-20% of the population (Sugiyono, 2023; Setyawan, 2022). Simple random sampling technique was applied to patients who met the inclusion criteria (age ≥18 years, length of stay ≥2 days at KRIS, willing to participate) and exclusion criteria (age <18 years, length of stay <2 days, unwilling), ensuring representativeness and reducing selection bias (Subhaktiyasa, 2024; Hartono et al., 2025).

The main instrument was the SERVQUAL questionnaire adapted from Ajeng Rizky Arinda (2021), consisting of 36 items (6 items per dimension: reliability, responsiveness, assurance, empathy, tangibles) for the independent variable of service quality, plus 6 items for the dependent variable of patient satisfaction, all on a Likert scale of 1-5 (strongly disagree to strongly agree). Validity was tested with Pearson correlation (calculated r > table r at $\alpha = 0.05$) and reliability with Cronbach's alpha ($\alpha \geq 0.70$), which has been verified in previous studies with an average α of 0.90 and a correlation coefficient of 0.80 (Ajeng Rizky Arinda, 2021; Sari et al., 2023). The score categorization was converted to a percentage (maximum score of 30 per dimension), with >60% classified as good/satisfied and ≤60% as bad/dissatisfied, according to the SERVQUAL interpretation standards (Sudaryono, 2022; Pratiwi & Santoso, 2024).

The research procedure began with the preparation stage, including instrument development, proposal submission, and obtaining permission from the RAA Soewondo Pati Regional General Hospital, as well as ethical clearance number 552/Z-7/KEPK/UMKU/I/2026 from the Research Ethics Committee of the Muhammadiyah Kudus University (Emzir, 2021). Primary data collection was conducted through the distribution of Google Forms with digital informed consent to eligible respondents, supplemented by secondary data from medical records for BOR and demographics; this process lasted for 4 weeks from February to March 2026 to capture the post-implementation conditions of KRIS (Setyawan, 2022; Pamungkas et al., 2023). Data completeness verification was carried out in real time to ensure a response rate of ≥80%, followed by initial processing before analysis (Subhaktiyasa, 2024).

Data analysis included a univariate stage with descriptive statistics (mean, median, frequency, percentage) to describe the characteristics of respondents and the distribution of variables using SPSS version 27, followed by bivariate with Chi-square and Spearman Rank tests to test for significant relationships ($p<0.05$) between SERVQUAL dimensions and patient satisfaction (Sugiyono, 2023; Setyawan, 2022). If the data were normal (Shapiro-Wilk test), further analysis used multiple linear regression to measure multivariate effects, while non-parametric tests were applied if the assumptions were violated, allowing for a comprehensive interpretation of the strength and direction of the relationship (Sari et al., 2023; Hartono et al., 2025).

Ethical considerations were strictly implemented in accordance with the Declaration of Helsinki, including written/digital informed consent explaining the purpose, risks, and right of withdrawal; confidentiality was maintained through anonymization codes, data was stored securely, and reporting avoided individual identification (Emzir, 2021; Pratiwi & Santoso, 2024). Approval from hospital management and the ethics committee ensured compliance, with potential bias minimized through enumerator training and independent data audits (Subhaktiyasa, 2024).

RESULTS AND DISCUSSION

General Overview of RAA Soewondo Pati Regional Hospital

RSUD RAA Soewondo Pati, a type B hospital owned by the Pati Regency Government on Jl. Dr. Susanto No. 114, serves outpatient, inpatient, emergency, and medical support services as the main referral for the local community. In line with Presidential Decree 59/2024, this hospital is implementing KRIS with a phased renovation: the initial stage of 2024 prepared 48 beds in the Dahlia, Edelweis, and Teratai 4 Rooms (16 beds each, meeting 12 criteria such as bed spacing, air conditioning, and wheelchair access); continued to the Mawar, Bougenvil, and Flamboyan Rooms. By the end of 2024, a total of 242 beds will be ready for operation for JKN patients.

Univariate Test

Respondent Characteristics

Respondents in this study were individuals who had undergone standard inpatient care at RAA Soewondo General Hospital, Pati. The results of univariate descriptive statistical analysis of respondent characteristics by gender are presented in Table 1.

Table 1. Respondent Characteristics Based on Gender

Variables	Category	Frequency (n)	%
Gender	Man	70	46.7
	Woman	80	53.3

Table 1 shows that the majority of respondents were female (53.3%), followed by male (46.7%).

Respondent Age

The results of the descriptive statistical univariate analysis regarding the characteristics of respondents based on age are presented in Table 2.

Table2Respondent Characteristics Based on Age

Variables	Category	Frequency (n)	%
Age	18–20 years	9	6.0
	21–30 years	48	32.0
	31–40 years	32	21.3
	41–50 years	30	20.0
	>50 years	31	20.7

Table 4.2 shows that the majority of respondentswere in the age group 21–30 years (32.0%), followed by 31–40 years (21.3%), 41–50 years (20.0%), and >50 years (20.7%).

Reliability Dimension

The results of the descriptive statistical univariate analysis regarding the reliability dimension categories are presented in Table 3.

Table 3. Univariate Results of Reliability Dimension

Variables	Category	Frequency (n)	%	Mean ± SD	Min–Max
Reliability	Good	135	90.0	22.15 ± 4.56	7–30
	Not good	15	10.0		

Responsiveness Dimension

The results of the descriptive statistical univariate analysis regarding the responsiveness dimension categories are presented in Table 4.

Table 4. Univariate Results of Responsiveness Dimensions

Variables	Category	Frequency (n)	%	Mean ± SD	Min–Max
Responsiveness	Good	137	91.3	15.81 ± 2.78	4–20
	Not good	13	8.7		

Guarantee Dimension

The results of the descriptive statistical univariate analysis regarding the guarantee dimension categories are presented in Table 5.

Table 4. Univariate Results of Assurance Dimension

Variables	Category	Frequency (n)	%	Mean ± SD	Min–Max
Guarantee	Good	121	80.7		8–30

	Not good	29	19.3	21.52 ± 4.99	

Dimension of Empathy

The results of the univariate analysis of descriptive statistics regarding the empathy dimension categories are presented in Table 6.

Table 5. Univariate Results of Empathy Dimensions

Variables	Category	Frequency (n)	%	Mean ± SD	Min–Max
Empathy	Good	128	85.3	22.56 ± 4.57	11–30
	Not good	22	14.7		

Dimensions of Direct Evidence

The results of the descriptive statistical univariate analysis regarding the direct evidence dimension categories are presented in Table 7.

Table 6. Univariate Results of Direct Evidence Dimensions

Variables	Category	Frequency (n)	%	Mean ± SD	Min–Max
Direct evidence	Good	119	79.3	25.68 ± 5.32	13–35
	Not good	31	20.7		

KRIS Patient Satisfaction Level

The results of the descriptive statistical univariate analysis regarding the satisfaction category are presented in Table 8.

Table 7. Univariate Results of KRIS Patient Satisfaction Level

Variables	Category	Frequency (n)	%	Mean ± SD	Min–Max
Satisfaction	Satisfied	131	87.3	23.11 ± 4.31	10–29
	Not satisfied	19	12.7		

Tables 3 through 8 show that most respondents rated service quality as good: reliability (90.0%), responsiveness (91.3%), assurance (80.7%), empathy (85.3%), and tangibles (79.3%). Satisfaction levels were also relatively high, with 87.3% of patients satisfied and 12.7% dissatisfied.

The Relationship between SERVQUAL Dimensions and KRIS Patient Satisfaction

The relationship between the dependent variable and the independent variable was assessed through the chi-square test on the category values and assessed through the Spearman Rank correlation test.

Chi-Square Test Results

Chi-Square Test Results for Gender Category with Patient Satisfaction Category

The results of the chi-square bivariate analysis between gender category and satisfaction category are presented in Table 9.

Table 8. Chi-Square Test of Gender Category with KRIS Patient Satisfaction Category

Variables	Category	Not satisfied n (%)	Satisfied n (%)	*p-value*	$\chi 2$	*df*
Gender	Man	8 (11.4)	62 (88.6)	0.670	0.182	1
	Woman	11 (13.8)	69 (86.3)			

Chi-Square Test Results for Age Category with Satisfaction Category

The results of the chi-square bivariate analysis between age category and satisfaction category are presented in Table 10.

Table 9. Chi-Square Test of Age Category with KRIS Patient Satisfaction Category

Variables	Category	Not satisfied n (%)	Satisfied n (%)	*p-value*	χ2	*df*
Age	18–20	5 (55.6)	4 (44.4)	<0.001*	19,464	4
	21–30	8 (16.7)	40 (83.3)			
	31–40	2 (6.3)	30 (93.8)			
	41–50	1 (3,3)	29 (96.7)			
	>50	3 (9.7)	28 (90.3)			

Chi-Square Test Results for Reliability Category with Satisfaction Category

The results of the chi-square bivariate analysis between the reliability category and the satisfaction category are presented in Table 11.

Table 10. Chi-Square Test of Reliability Category with KRIS Patient Satisfaction Category

Variables	Category	Not satisfied n (%)	Satisfied n (%)	*p-value*	χ2	*df*
Reliability	Not good	4 (26.7)	11 (73.3)	0.086	2,953	1
	Good	15 (11.1)	120 (88.9)			

Source: Primary data, 2026

Chi-Square Test Results for Responsiveness Category with Satisfaction Category

The results of the chi-square bivariate analysis between the responsiveness category and the satisfaction category are presented in Table 12.

Table 11. Chi-Square Test of Responsiveness Category with KRIS Patient Satisfaction Category

Variables	Category	Not satisfied n (%)	Satisfied n (%)	*p-value*	χ2	*df*
Responsiveness	Not good	2 (15.4)	11 (84.6)	0.758	0.095	1
	Good	17 (12.4)	120 (87.6)			

Chi-Square Test Results for Assurance Category with Satisfaction Category

The results of the chi-square bivariate analysis between the guarantee category and the satisfaction category are presented in table 13.

Table 12. Chi-Square Test of Assurance Category with KRIS Patient Satisfaction Category

Variables	Category	Not satisfied n (%)	Satisfied n (%)	*p-value*	χ2	*df*
Guarantee	Not good	6 (20.7)	23 (79.3)	0.148	2,092	1
	Good	13 (10.7)	1089.3)			

Chi-Square Test Results for Empathy Category with Satisfaction Category

The results of the chi-square bivariate analysis between the empathy category and the satisfaction category are presented in table 14.

Table 13. Chi-Square Test of Empathy Category with KRIS Patient Satisfaction Category

Variables	Category	Not satisfied n (%)	Satisfied n (%)	*p-value*	χ2	*df*
Empathy	Not good	3 (13.6)	19 (86.4)	0.882	0.022	1

	Good	16 (12.5)	112 (87.5)			

Chi-Square Test Results for Physical Evidence Category with Satisfaction Category

The results of the chi-square bivariate analysis between the physical evidence category and the satisfaction category are presented in table 15.

Table 14. Chi-Square Test of Physical Evidence Category with KRIS Patient Satisfaction Category

Variables	Category	Not satisfied n (%)	Satisfied n (%)	*p-value*	χ2	*df*
Physical evidence	Not good	5 (16.1)	26 (83.9)	0.515	0.423	1

All chi-square test results in each category showed that only the age variable was significantly related to patient satisfaction, with a value of $\chi^2 = 19.464$; df = 4; $p < 0.001$, which means the distribution of satisfied and dissatisfied patients differed significantly in each age group. In contrast, gender did not show a significant relationship with satisfaction ($\chi^2 = 0.182$; df = 1; $p = 0.670$), so the proportion of satisfaction between male and female patients was relatively similar. The service quality dimensions categorized as good and bad were also not significantly related to satisfaction, respectively indicated by reliability ($\chi^2 = 2.953$; df = 1; $p = 0.086$), responsiveness ($\chi^2 = 0.095$; df = 1; $p = 0.758$), assurance ($\chi^2 = 2.092$; df = 1; $p = 0.148$), empathy ($\chi^2 = 0.022$; df = 1; $p = 0.882$), and physical evidence ($\chi^2 = 0.423$; df = 1; $p = 0.515$), all of which had $p > 0.05$ so it can be concluded that they were not significantly associated with the patient satisfaction category.

Spearman Rank Analysis Results

Spearman Rank analysis in this study was carried out because the data was not normally distributed, which is presented in table 5.

Table 15. Data Normality Test

Variables	*Mean*	*Elementary School*	*Skewness*	*SE Skew*	*zSkewness*	*Kurtosis*	*SE Kurt*	*zKurtosis*
Reliability	22.15	4.56	−0.80	0.20	-4.00	1.25	0.40	3.13
Responsiveness	15.81	2.78	−0.65	0.20	-3.25	0.90	0.40	2.25
Guarantee	21.52	4.99	−0.72	0.20	−3.60	0.80	0.40	2.00
Empathy	22.56	4.57	−0.60	0.20	-3.00	0.70	0.40	1.75
Direct evidence	25.68	5.32	−0.85	0.20	-4.25	1.40	0.40	3.50
Satisfaction	23.11	4.31	−0.78	0.20	-3.90	1.10	0.40	2.75

Data is stated to deviate from normality descriptively if the z-skewness or z-kurtosis value is outside the range of ±1.96 ($\alpha = 0.05$). Table 16 shows that most variables have $|z| > 1.96$ so that the score distribution is not perfectly normal and further analysis uses a nonparametric test (Spearman).

Spearman Rank Test Results of Gender Variable with Patient Satisfaction

The results of the Spearman Rank bivariate analysis between the gender variable and patient satisfaction in standard inpatient care classes are presented in Table 17.

Table 16. Spearman Rank Test between Gender Variable and KRIS Patient Satisfaction

Variables	*rs*	*p-value*
Gender	−0.037	0.650

Spearman Rank Test Results of Age Variable with Patient Satisfaction

The results of the Spearman Rank bivariate analysis between the respondent's age variable and patient satisfaction with standard inpatient care are presented in Table 18.

Table 17. Spearman Rank Test between Age Variable and KRIS Patient Satisfaction

Variables	*rs*	*p-value*
Respondent's age	0.233	0.004*

Spearman Rank Test Results of Reliability Variables with Patient Satisfaction

The results of the Spearman Rank bivariate analysis between the Reliability variable and patient satisfaction in standard inpatient care are presented in Table 19.

Table 18. Spearman Rank Test between Reliability Variables and KRIS Patient Satisfaction

Variables	*rs*	*p-value*
Reliability	0.121	0.140

Spearman Rank Test Results of Responsiveness Variable with Patient Satisfaction

The results of the Spearman Rank bivariate analysis between the responsiveness variable and patient satisfaction in standard inpatient care are presented in Table 20.

Table 19. Spearman Rank Test between Responsiveness Variable and KRIS Patient Satisfaction

Variables	*rs*	*p-value*
Responsiveness	0.007	0.934

Spearman Rank Test Results of Assurance Variables with Patient Satisfaction

The results of the Spearman Rank bivariate analysis between the assurance variable and patient satisfaction in standard inpatient care are presented in Table 21.

Table 20. Spearman Rank Test between Responsiveness Variable and KRIS Patient Satisfaction

Variables	*rs*	*p-value*
Guarantee	0.096	0.242

Spearman Rank Test Results of Empathy Variable with Patient Satisfaction

The results of the Spearman Rank bivariate analysis between the empathy variable and patient satisfaction in standard inpatient care are presented in Table 22.

Table 21. Spearman Rank Test between Empathy Variable and KRIS Patient Satisfaction

Variables	*rs*	*p-value*
Empathy	0.038	0.646

Spearman Rank Test Results of Physical Evidence Variables with Patient Satisfaction

The results of the Spearman Rank bivariate analysis between the physical evidence variables and patient satisfaction in standard inpatient care are presented in Table 23.

Table 22. Spearman Rank Test between Empathy Variable and KRIS Patient Satisfaction

Variables	*rs*	*p-value*
Physical evidence	0.201	0.014*

Overall, the Spearman rank correlation test showed a significant positive correlation between age and satisfaction ($rs \approx 0.23$; $p < 0.01$), indicating that older patients tended to report higher levels of satisfaction. Furthermore, physical evidence also significantly correlated with satisfaction ($rs \approx 0.20$; $p < 0.05$), meaning that the better the infrastructure and physical environment of the treatment room, the higher the patient satisfaction score. The dimensions of reliability, responsiveness, assurance, and empathy showed positive correlation coefficients but were small and not statistically significant ($p > 0.05$), so that at the score level, no significant relationship was found between these dimensions and satisfaction.. Gender was also not significantly correlated with satisfaction scores ($p > 0.05$).

Discussion

Overview of service quality and satisfaction in the KRIS space

The results of the study indicate that the implementation of the Standard Inpatient Class (KRIS) at RAA Soewondo Pati Regional Hospital resulted in a relatively high level of service quality and satisfaction; the

majority of patients rated all dimensions of service quality in the good category and 87.3% of respondents stated that they were satisfied. In line with other studies that use the SERVQUAL concept in inpatient wards, it shows that the five dimensions of SERVQUAL (reliability, responsiveness, assurance, empathy, and direct evidence) contribute to patient satisfaction when basic service standards are met (Pamungkas et al., 2023); (Nyoman Dharma Wiasa et al., 2025); (Hidayah et al., 2022); (Rosilawati et al., 2025); (Rahmatia et al., 2025). In theory, these results are in line with the SERVQUAL idea which states that patients' views on service quality will be better if hospitals can maintain consistent service standards in terms of reliability, responsiveness, assurance, attention, and physical evidence (Rahayu, 2024).

The KRIS policy in Presidential Regulation No. 59 of 2024 emphasizes equal access and minimum standards for room facilities, such as the number of beds per room, ventilation, and bathroom availability, which are designed to reduce disparities between treatment classes (Presidential Regulation of the Republic of Indonesia Number 59 of 2024 concerning the Third Amendment to Presidential Regulation Number 82 of 2018 concerning Health Insurance, 2024); (Astuti et al., 2025); (Hartono et al., 2025). The implementation of these structural standards is in line with the concept that improving the physical and administrative aspects of a hospital can improve the inpatient experience and overall satisfaction (Ferreira, Vieira, et al., 2023). The implementation of KRIS, which regulates space, bed ratio, air circulation, lighting, and facility conditions, also helps meet patients' basic expectations of comfort and safety during treatment (Budi Indrawati, 2022).

Relationship between Gender and Patient Satisfaction

Chi-square analysis of categorical data showed no significant relationship between gender and satisfaction category ($p = 0.670$). This result was supported by Spearman's correlation, which also showed a very weak and insignificant relationship between gender and satisfaction scores ($rs = -0.037$; $p = 0.650$). Therefore, it can be concluded that male and female patients have relatively similar experiences and satisfaction ratings with services in the KRIS room.

This is in line with several studies that also found that gender differences do not play a major role in assessing satisfaction (Sihaloho & Herliana, 2019), compared to other factors such as communication quality (Rusnoto et al., 2019); (Dora et al., 2019), speed of service (Hidayat et al., 2025), and comfort of facilities. This is also in line with the KRIS concept which does not differentiate the quality of service between patients from various backgrounds (Presidential Regulation of the Republic of Indonesia Number 59 of 2024 concerning the Third Amendment to Presidential Regulation Number 82 of 2018 concerning Health Insurance, 2024). When service standards have been standardized through KRIS, service variations based on gender become smaller so that they do not cause significant differences in perceptions of satisfaction (Mey Lona Verawaty Zendrato, 2022); (Rahmatia et al., 2025); (Dewi et al., 2024).

Relationship between Respondent Age and Patient Satisfaction

In contrast to gender, age plays a clearer role in satisfaction. A chi-square test comparing age and satisfaction categories yielded a p-value <0.001, indicating a significant relationship between age and satisfaction. Spearman's correlation analysis also showed a significant positive relationship between age and satisfaction scores ($rs = 0.234$; $p = 0.004$). This means that the older the patient, the higher their level of satisfaction with the service.

Clinically and socially, older adults typically have different expectations than younger patients. Older patients often prioritize basic comfort, friendliness of staff, and assurance of care over technical aspects or speed of service (Fandi Sudiasmo, 2021). The implementation of the KRIS (Comprehensive Hospital Rehabilitation System), which regulates standards for treatment rooms, such as sufficient beds, good ventilation, adequate lighting, and privacy, can provide a greater sense of security and comfort for older patients, leading to greater satisfaction (Atmim Rizki Fitriani & Hamzah, 2025). Furthermore, older patients may have more experience with healthcare services, so they can see the difference between before and after the KRIS implementation. Changes in physical condition and management methods may be more noticeable to this age group, leading them to perceive the current service as more satisfactory.

The Relationship between the Dimensions of Reliability, Responsiveness, Assurance, and Empathy

Categorically, most patients rated reliability, responsiveness, assurance, and empathy as good. However, Spearman's correlation analysis showed that these four dimensions had no significant relationship with satisfaction scores: reliability ($rs = 0.121$; $p = 0.140$), responsiveness ($rs = 0.007$; $p = 0.934$), assurance ($rs = 0.096$; $p = 0.242$), and empathy ($rs = 0.038$; $p = 0.646$). All correlations were weak, with p-values above 0.05. This phenomenon can be viewed from two perspectives. First, because the average scores for reliability, responsiveness, assurance, and empathy were already quite high, the differences in scores among respondents were not significant. Statistically, these small differences make it difficult for correlation analysis to detect a

connection, so that even if patients are satisfied with the services received, small differences between individuals are not significant enough to show a strong relationship with the level of satisfaction (Mahmudah, Yessi Harnani, Ismaniar, 2024).

Second, in the implementation of KRIS, which focuses on standardizing basic procedures and services, staff attitudes (such as reliability, responsiveness, assurance, and empathy) may be sufficient for most patients. When basic needs are met, the additional impact of improved service attitudes on differences in satisfaction levels will be smaller compared to other factors that still vary, such as the condition of the physical facilities or personal preferences regarding the treatment room environment (Rizky et al., 2026). These findings suggest that in this hospital, staff behavior is not the most important factor for patient satisfaction, but rather a basic requirement that must be met. To further improve patient satisfaction, the hospital needs to consider more specific measures, such as improving communication with each other, providing clearer information, or increasing empathy, which may not be fully captured by current measurement tools.

The Relationship of Physical Evidence (Direct Evidence) to Patient Satisfaction

In contrast to the behavioral dimension, tangible evidence showed a significant relationship with satisfaction in the score analysis. The Spearman correlation between tangible evidence scores and satisfaction scores was rs = 0.201 with p = 0.014, indicating a weak but statistically significant positive relationship. This indicates that the better patients' assessment of the physical condition of the treatment room, including cleanliness, comfort, completeness of facilities, and tidiness of the environment, the higher their satisfaction.

These findings align with the core of the KRIS policy, which aims to standardize and improve the physical conditions of treatment rooms. A more comfortable space, appropriate spacing between beds, good air circulation, adequate lighting, and basic facilities such as bathrooms, mobility aids, and family support significantly impact a patient's experience during hospitalization. In many previous studies, physical evidence has often been cited as a key factor influencing patient satisfaction in hospitals because it can be clearly felt and seen (Yuliantoharinugroho, Mochamad Rofik, 2023).

In the context of RAA Soewondo Pati Regional Hospital, tangible evidence can illustrate the success of KRIS implementation. When patients see clear changes in the physical environment, such as cleaner and less crowded rooms, more comfortable beds, and more neatly arranged equipment, it conveys the impression that the hospital cares about patient dignity and comfort, which then improves overall satisfaction ratings.

Integration of findings with the SERVQUAL framework and KRIS implementation

Overall, this study revealed that in the KRIS treatment room, physical evidence and patient age were the two things that most influenced satisfaction, while behavioral factors such as reliability, responsiveness, assurance, and empathy appeared uniform and did not appear to be differentiating factors.

From a policy perspective, these results indicate that KRIS has successfully improved and standardized the structural elements and physical environment of services, particularly for the elderly, who are the primary users of JKN services. However, to achieve more comprehensive service quality, hospital management must continue to invest in strengthening behavioral aspects through training in good communication, increasing empathy, and strengthening the culture of safety and clinical assurance so that all aspects of SERVQUAL can truly contribute to patient satisfaction. patients (Susanty & Hardisman,2025).

CONCLUSION

This study shows that the implementation of the Standard Inpatient Class (KRIS) at RAA Soewondo Pati Regional Hospital has driven relatively high levels of service quality and satisfaction, with the majority of patients rating all SERVQUAL dimensions as good and 87.3% of respondents stating they were satisfied. However, from a statistical perspective, only patient age and the physical evidence dimension were significantly correlated with satisfaction, while gender, reliability, responsiveness, assurance, and empathy, although rated fairly well, did not show a significant relationship. These findings indicate that KRIS tends to strengthen structural standards and physical facilities, but has not yet fully produced large variations in the behavioral dimensions of service, so that the implications are more visible in improvements in comfort and the physical environment rather than significant differences in emotional experiences and interpersonal interactions with health workers.

Some limitations of this study include its cross-sectional design that does not capture long-term changes, its limited sample size to a single hospital, and its focus on aggregate SERVQUAL scores that may obscure variations in certain subdimensions. Future research requires a longitudinal study that examines the development of quality and satisfaction before, during, and after the completion of KRIS implementation, as well as an in-depth qualitative study of staff and patient perceptions of the policy. The practical implication is that the management of RSUD RAA Soewondo Pati needs to continue renovating its physical facilities while strengthening communication, empathy, and patient safety training so that the behavioral dimension of service truly becomes the main differentiator in increasing satisfaction, not just a relatively met minimum requirement.

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