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SATISFACTION UNDER THE STANDARD INPATIENT CLASS POLICY IN SOUTH SUMATERA: A MIXED-METHODS STUDY USING THE HCAHPS FRAMEWORK

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ABSTRACT

Patient satisfaction serves as a key indicator of hospital service quality and reflects the success of Indonesia's Universal Health Coverage (UHC) reform in the context of the *Standard Inpatient Class (Kelas Rawat Inap Standar, KRIS)* policy. To ensure equitable healthcare delivery, hospitals must evaluate not only service accessibility but also patient-centered experiences. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) provides a standardized tool for assessing inpatient satisfaction, which remains limited in Indonesian hospital settings. This study aimed to assess inpatient satisfaction at a Semi-Urban Hospital. A mixed-method design with a convergent parallel approach was applied. The quantitative component used the HCAHPS questionnaire among 142 inpatients selected through purposive sampling and analyzed using descriptive statistics. The qualitative component employed a phenomenological approach with 13 informants (patients, nurses, administrators), analyzed using thematic analysis. Triangulation was used to enhance data validity. Inpatient satisfaction was moderate, with communication and interpersonal interactions representing key strengths, while pain management, medication communication, responsiveness, and environmental comfort remained areas for improvement. Qualitative findings indicated that patient experiences were influenced by communication, empathy, responsiveness, facility comfort, and perceptions of fairness during KRIS implementation. Continuous patient feedback, communication training, and improvements in service responsiveness may support patient-centered quality improvement.

Kata Kunci:

kepuasan;
rawat inap; rumah sakit.

ABSTRAK

Kepuasan pasien merupakan indikator penting kualitas layanan rumah sakit dan mencerminkan keberhasilan reformasi Jaminan Kesehatan Nasional (JKN) Indonesia melalui kebijakan Kelas Rawat Inap Standar (KRIS). Untuk memastikan penyediaan layanan kesehatan yang adil, rumah sakit harus mengevaluasi tidak hanya aksesibilitas layanan tetapi juga pengalaman pasien yang berpusat pada pasien. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) menyediakan alat baku untuk menilai kepuasan pasien rawat inap, yang masih terbatas digunakan pada rumah sakit Indonesia. Studi ini bertujuan untuk menganalisis kepuasan pasien rawat inap di Rumah Sakit Semi-Urban. Desain campuran dengan pendekatan konvergen paralel diterapkan. Komponen kuantitatif menggunakan kuesioner HCAHPS pada 142 pasien rawat inap yang dipilih melalui sampling purposive dan dianalisis menggunakan statistik deskriptif. Komponen kualitatif menggunakan pendekatan fenomenologis dengan 13 informan (pasien, perawat, administrator), dianalisis menggunakan analisis tematik. Triangulasi memastikan validitas data. Tingkat kepuasan pasien berada pada kategori sedang. Komunikasi dan interaksi antarpribadi menjadi kekuatan utama, sementara manajemen nyeri, komunikasi terkait pengobatan, responsivitas, dan kenyamanan lingkungan masih memerlukan perbaikan. Temuan kualitatif menunjukkan bahwa pengalaman pasien didorong oleh komunikasi, empati, responsivitas, kenyamanan fasilitas, serta persepsi mengenai keadilan selama penerapan KRIS. Umpan balik pasien yang berkelanjutan, pelatihan komunikasi, dan peningkatan responsivitas layanan dapat mendukung upaya peningkatan mutu yang berpusat pada pasien.

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INTRODUCTION

Patient satisfaction has become a cornerstone of healthcare quality evaluation and a benchmark for institutional accountability. It extends beyond a subjective perception of care to represent how effectively health systems meet patients' expectations in terms of safety, communication, empathy, and service efficiency (Millien & Joseph, 2023). Within the framework of value-based healthcare, patient experience is increasingly recognized as a critical indicator of system performance and as a driver for continuous quality improvement (Davidson et al., 2017). One of the most widely used international standards for measuring patient satisfaction is the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), a national survey instrument developed by the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) in the United States. This tool evaluates patients' hospital experiences across key dimensions such as provider communication, staff responsiveness, pain management, medication information, and the cleanliness and quietness of the hospital environment (Giordano et al., 2010).

The Kelas Rawat Inap Standar (KRIS) is a policy reform within Indonesia's National Health Insurance (Jaminan Kesehatan Nasional/JKN) that aims to establish a more equitable and standardized minimum level of inpatient care for JKN participants. The policy is formally established through Presidential Regulation No. 59 of 2024, which stipulates that JKN participants are entitled to health services according to their health needs and a standardized inpatient class (Government of Indonesia, 2024). The implementation framework emphasizes a gradual transition toward standardized inpatient facilities and requires coordination among the Ministry of Health, health offices, hospital management, hospital owners, and other relevant stakeholders, supported by monitoring and evaluation, regulatory guidance, and hospital readiness assessment (Ministry of Health of the Republic of Indonesia, 2024; Center for Health Policy Development, 2024). A central component of KRIS is the standardization of inpatient facilities through 12 criteria, covering building materials, ventilation, lighting, electrical outlets and nurse-call systems, bedside cabinets, room temperature, patient grouping, maximum bed density of four beds per room, privacy partitions, bathrooms, accessibility, and oxygen outlets (Ministry of Health of the Republic of Indonesia, 2026a). These standards are intended to ensure that all JKN participants receive a more consistent minimum level of safety, comfort, privacy, accessibility, and quality regardless of the hospital or previous inpatient class (Ministry of Health of the Republic of Indonesia, 2026b). Consequently, KRIS may have important implications for patient experience and satisfaction, particularly through improvements in physical comfort, privacy, perceived equity, and safety. However, the transition may also affect hospital bed capacity, bed occupancy, infrastructure requirements, and hospital revenue, making continuous monitoring and mitigation important to ensure that improvements in standardization do not adversely affect patient satisfaction during implementation (Center for Health Policy Development, 2024)

In low- and middle-income countries (LMICs), including Indonesia, the shift toward patient-centered service models has gained importance with the implementation of Universal Health Coverage (UHC). The *Standard Inpatient Class* (*Kelas Rawat Inap Standar*, KRIS) policy aims to ensure equitable inpatient services across all socioeconomic groups. However, while structural equity has been emphasized, there is limited empirical evidence on how these reforms affect patient satisfaction and perceived service quality. This gap is critical because satisfaction is both a measure of care quality and a predictor of patient adherence, trust, and health outcomes (Shan et al., 2016). Existing evidence on KRIS has largely focused on implementation readiness, infrastructure compliance, and the feasibility of meeting standardized inpatient requirements, while empirical evidence linking specific aspects of KRIS implementation to patients' perceived service quality and satisfaction remains limited and context-specific. Moreover, it remains unclear whether improvements in structural conditions are sufficient to enhance satisfaction or whether patient experience is also shaped by service-process dimensions, such as responsiveness, communication, and staff interaction. This distinction is important because patient satisfaction reflects the interaction between patients' expectations and their experience of care and may therefore provide an important patient-centered indicator of whether a structural equity reform is translating into meaningful improvements in service quality.

Studies across different healthcare systems consistently identify communication quality, provider empathy, and service responsiveness as dominant determinants of satisfaction. In developing

contexts, operational inefficiencies, long waiting times, and inconsistent communication remain major barriers. In Malawi, only 8.4% of hospital patients expressed high satisfaction, with dissatisfaction driven by overcrowding, inadequate communication, and perceived favoritism (Sinyiza et al., 2022). Likewise, a study in Rwanda found that overall satisfaction (52.6%) was moderate, reflecting systemic constraints and resource disparities (Sebera et al., 2024). These findings suggest that improving satisfaction requires not only technical efficiency but also relational care that fosters trust and emotional engagement. Socio-demographic variables also shape satisfaction patterns. Older patients and those with lower education levels tend to report higher satisfaction, possibly due to lower expectations or cultural norms emphasizing respect for authority (Sebera et al., 2024).

In contrast, transparent policies and equitable access, such as Indonesia's KRIS initiative, aim to restore fairness by standardizing room facilities and service levels. However, systemic challenges such as limited human resources, inadequate medical supplies, and poor facility maintenance continue to affect perceived quality (Sebera et al., 2024; Sinyiza et al., 2022). Beyond structural aspects, interpersonal experiences remain the most significant contributors to satisfaction. Studies in Europe and Asia confirm that emotional connection, empathy, and respect have a greater impact on satisfaction than clinical outcomes alone(García-Alfranca et al., 2018).

Additionally, there is limited understanding of how UHC reforms, including KRIS, affect service quality and patient experience in Indonesia. While previous studies have focused on access and equity, few have examined whether structural standardization translates into improved satisfaction. Addressing this gap is vital for ensuring that policy implementation aligns with patient-centered outcomes.

The novelty of this study lies in its mixed-method approach, which integrates quantitative HCAHPS analysis with qualitative thematic exploration to capture both measurable satisfaction levels and the lived experiences of patients. This dual approach allows a comprehensive evaluation of how the KRIS policy influences patient satisfaction within Indonesian hospitals. Unlike prior research focusing solely on clinical or operational indicators, this study incorporates emotional, relational, and contextual factors, providing a holistic understanding of patient-centered quality. This study aimed to assess inpatient satisfaction across HCAHPS dimensions and explore patients', nurses', and hospital administrators' perceptions of communication, responsiveness, environmental comfort, and fairness during KRIS implementation in a semi-urban hospital in South Sumatra, Indonesia.

METHOD

Type of Research

This study employed a mixed-method design using a convergent parallel approach, in which quantitative and qualitative data were collected and analyzed separately but integrated during interpretation. The rationale for using mixed methods was to combine the numerical breadth of patient satisfaction data with the contextual depth of patient narratives, thereby providing a comprehensive understanding of hospital service quality (Robinson, 2007).

Place and Time of Research

The research was conducted at a semi-urban hospital in South Sumatra, Indonesia, that has implemented the Standard Inpatient Class (Kelas Rawat Inap Standar / KRIS) policy under Indonesia's Universal Health Coverage program. The hospital serves a diverse patient population, predominantly those covered by the National Health Insurance (Jaminan Kesehatan Nasional / JKN).

Population and Sample

The study population included adult inpatients aged 18 years and above who had been hospitalized for at least two days in the general medical or surgical wards. The sample size was determined using the Slovin formula with a 5% margin of error. A total of 142 respondents were recruited through purposive sampling to ensure representation from various wards. Eligible inpatients who met the predefined inclusion and exclusion criteria were subsequently recruited until the required sample size was achieved. Data collection was conducted between September and October 2025 by trained enumerators. Respondents were assured of anonymity and voluntary participation.

Data Collection

The quantitative phase used a cross-sectional survey approach with the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) questionnaire. The instrument was adapted and translated into Bahasa Indonesia. The questionnaire consisted of 27 items distributed across six key dimensions: (1) communication with doctors, (2) communication with nurses, (3) staff responsiveness, (4) pain management, (5) medication communication, and (6) hospital environment. The qualitative phase adopted a phenomenological approach, focusing on understanding the lived experiences of patients and staff concerning hospital service delivery under the KRIS framework. Patient satisfaction was assessed using 21 HCAHPS items, with each item scored from 1 to 4, resulting in a possible total score ranging from 21 to 84. Based on the predetermined cut-off, respondents with a total score of 53–84 were categorized as satisfied, whereas those with a score of 21–52 were categorized as not satisfied. The proportion of satisfied respondents was then calculated as the number of respondents classified as satisfied divided by the total number of respondents, multiplied by 100. Thirteen informants participated, consisting of six patients, four nurses, and three hospital administrators. Data were gathered through semi-structured interviews, guided by open-ended questions exploring communication, fairness, empathy, and environmental comfort. Interviews were conducted face-to-face, recorded with consent, and transcribed verbatim.

Data Analysis and Processing

Descriptive statistics were used to summarize the study variables. Categorical variables were presented as frequency distributions and proportions (percentages). The descriptive analysis included respondents' sociodemographic and hospital characteristics as well as inpatient patient satisfaction. Results were presented in frequency and percentage tables to describe the distribution of respondents according to their characteristics and satisfaction categories. Thematic analysis was used to identify recurring patterns and themes, following the six-step framework proposed by Braun and Clarke: familiarization, coding, theme development, reviewing, defining, and reporting. Data triangulation between informant groups (patients, nurses, and management) was used to enhance the credibility of findings, while peer debriefing enhanced analytical validity (Braun & Clarke, 2006). Quantitative and qualitative results were integrated during the interpretation phase. The convergence model allowed for the comparison of numerical trends and thematic insights to identify consistencies and discrepancies between patient-reported satisfaction scores and qualitative perceptions. Integration provided a deeper understanding of how the KRIS policy influenced both the measurable and experiential aspects of patient satisfaction.

Ethical Clearance

This research has obtained ethical approval for research involving human subjects from the Ethics Committee of the Faculty of public health, sriwijaya university with approval number: 524/UN9.FKM/TU.KKE/2025.

RESULT

Table 1. Characteristics of Respondents

Variable	Category	Frequency (n)	Percentage (%)
Sex	Male	44	31.0
	Female	98	69.0
Highest Education Level	No formal education	4	2.8
	Elementary school	37	26.1
	Junior high school	23	16.2
	Senior high school	71	50.0
	Diploma (D3)	1	0.7
	Bachelor's degree (S1)	5	3.5
	Master's degree (S2)	1	0.7

Variable	Category	Frequency (n)	Percentage (%)
Occupation	Unemployed	10	7.0
	Civil servant	2	1.4
	Military/Police	1	0.7
	Trader	4	2.8
	Farmer	16	11.3
	Retired	10	7.0
	Self-employed	23	16.2
	Housewife	61	43.0
	Student	9	6.3
	Teacher	6	4.2
Insurance Class	Class 1	27	19.0
	Class 2	20	14.1
	Class 3	95	66.9
Hospitalization Experience	First-time	110	77.5
	More than once	32	22.5
Total		**142**	**100.0**

Based on **Table 1**, the majority of respondents were female (69.0%), while males accounted for 31.0% of the sample. In terms of educational attainment, most respondents had completed senior high school (50.0%), followed by elementary education (26.1%) and junior high school (16.2%). Only a small proportion had attained higher education, with 3.5% holding a bachelor's degree and less than 1% holding a diploma or master's degree. Regarding occupation, nearly half of the respondents were housewives (43.0%), followed by self-employed individuals (16.2%) and farmers (11.3%), indicating that the sample was dominated by informal and domestic occupations. With respect to insurance participation, most respondents were enrolled in Class 3 (66.9%), while 19.0% and 14.1% were registered in Class 1 and Class 2, respectively. Concerning hospitalization experience, the majority of respondents (77.5%) reported being hospitalized for the first time, whereas 22.5% had experienced inpatient care more than once. Overall, these findings suggest that the study population was predominantly female, had a relatively low to moderate educational background, was largely engaged in informal employment or domestic activities, and mainly belonged to the lowest insurance class.

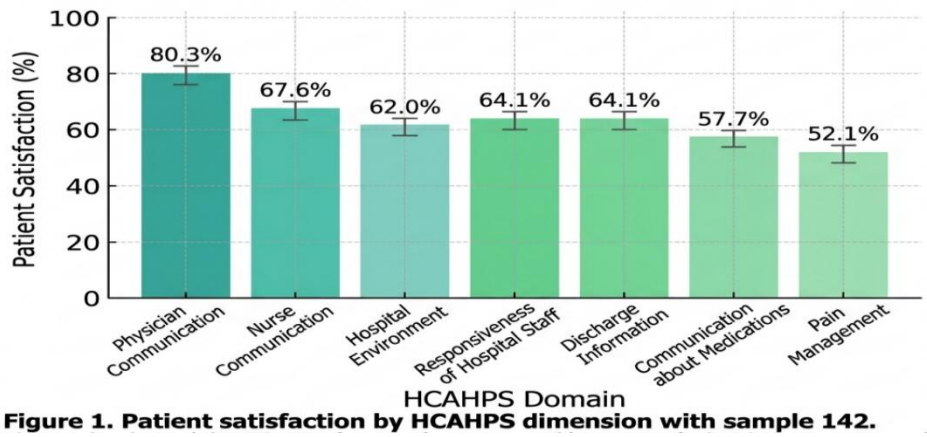

Figure 1. Patient satisfaction by HCAHPS dimension with sample 142.

Quantitative finding

Figure 1 using the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey revealed an overall satisfaction rate of 53.5%, indicating a moderate level of patient satisfaction.

The highest satisfaction scores were observed in communication with doctors (80.3%) and nurses (67.6%), while pain management (52.1%) and medication communication (57.7%) received the lowest ratings. The hospital environment scored moderately (62.0%), reflecting acceptable but improvable conditions.

Qualitative finding

Qualitative interviews with 13 informants (six patients, four nurses, three administrators) revealed five key themes: (1) communication and empathy, (2) hospital environment and comfort, (3) responsiveness, (4) fairness under KRIS implementation, and (5) expectation versus reality. Patients valued doctors and nurses who provided clear explanations and demonstrated empathy.

Participants expressed clear expectations for improvements in the quality and comfort of facilities in the Standard Inpatient Class (KRIS), particularly regarding room conditions, air conditioning, and bed quality. One respondent emphasized the need for greater comfort during hospitalization:

"Facilities should be improved so that patients feel more comfortable, especially regarding room temperature and air conditioning" (K1).

Concerns about the functionality and stability of inpatient beds were also reported, with respondents expecting better facility performance:

"The facilities should be better, including properly functioning air conditioning and stable beds" (K2).

Several respondents compared current KRIS facilities with previous class-based inpatient services, indicating expectations for comparable or improved standards:

"The facilities should be better than before, similar to those in Class 1, 2, and 3" (K3).

In addition, limited room availability and prolonged waiting times were highlighted as critical issues. One participant described extended waiting periods prior to admission:

"Patients often have to wait for a long time in the emergency department due to limited room availability, sometimes up to 24 hours" (K4).

Overall, these shortened quotations reflect patients' expectations for enhanced comfort, functional infrastructure, and improved capacity within the implementation of KRIS.

Participants emphasized expectations for faster responsiveness, continuous service improvement, patient comfort, and equitable treatment within KRIS implementation. The following shortened quotations illustrate these expectations:

"Services should respond faster when patients need assistance" (K1).
"Service quality has improved but still needs enhancement" (K2).
"Services should be better than previous experiences" (K3).
"Services should be improved and provided equally to all patients" (K4).

Table 2. Joint Display of Quantitative and Qualitative Findings on Patient Satisfaction under KRIS Implementation

HCAHPS dimension / quantitative finding	Qualitative theme and supporting evidence	Integrated interpretation
Communication with doctors: 80.3% satisfaction	Communication and empathy: Patients valued doctors and nurses who provided clear explanations and demonstrated empathy.	The high satisfaction with doctor communication was consistent with qualitative findings emphasizing the importance of clear explanations and empathetic interactions. This convergence suggests that interpersonal communication was an important positive aspect of the inpatient experience.
Communication with nurses: 67.6% satisfaction	Communication and empathy; Responsiveness: Participants emphasized the importance of staff communication and faster responses when assistance was needed.	The relatively favorable satisfaction with nurse communication was supported by qualitative findings. However, requests for faster responses indicate that good communication did not necessarily translate into consistently responsive care.

HCAHPS dimension / quantitative finding	Qualitative theme and supporting evidence	Integrated interpretation
Hospital environment: 62.0% satisfaction	Hospital environment and comfort: Participants identified room conditions, air conditioning, bed quality, and overall comfort as areas requiring improvement.	The moderate quantitative rating was complemented by qualitative concerns regarding physical comfort and facility functionality. Together, these findings indicate that the hospital environment remained an important area for improvement under KRIS implementation.
Pain management: 52.1% satisfaction	Responsiveness and expectation versus reality: Participants expected faster responses when assistance was needed and continued improvement in service quality.	The relatively low satisfaction with pain management may reflect broader concerns regarding responsiveness and patients' expectations of timely care. However, the qualitative data did not specifically attribute dissatisfaction to pain management, indicating a complementary rather than direct explanation.
Medication communication: 57.7% satisfaction	Communication and empathy; Expectation versus reality: Participants valued clear explanations and expected service quality to improve beyond previous experiences.	The moderate satisfaction with medication communication was broadly consistent with participants' emphasis on clear communication and improved service delivery. The qualitative findings suggest that communication remained an area in which patients expected further improvement.
Overall patient satisfaction: 53.5%	Fairness under KRIS; Expectation versus reality: Participants expected improved facilities, equitable treatment, better service quality, and standards comparable to or better than previous inpatient classes.	The overall moderate satisfaction level was complemented by qualitative findings showing that patients viewed KRIS as an opportunity for improved comfort, service quality, and equitable treatment. However, expectations regarding facility quality, responsiveness, and service capacity were not always fully aligned with patients' experiences.
Overall pattern	Five themes: communication and empathy; hospital environment and comfort; responsiveness; fairness under KRIS; and expectation versus reality.	Integration of the findings indicates that patient satisfaction under KRIS was shaped not only by standardized physical facilities but also by interpersonal communication, responsiveness, perceived fairness, and the extent to which actual care met patients' expectations.

Integration of Quantitative and Qualitative Findings

Integration of the quantitative and qualitative findings demonstrated both convergence and complementarity across the data sources. Quantitatively, overall patient satisfaction was 53.5%, with the highest satisfaction observed for communication with doctors (80.3%) and nurses (67.6%), whereas pain management (52.1%) and medication communication (57.7%) received comparatively lower ratings. These findings were broadly consistent with the qualitative evidence, in which participants valued clear communication and empathy but also identified responsiveness as an area requiring improvement. The moderate satisfaction with the hospital environment (62.0%) was further contextualized by participants' concerns regarding room temperature, air conditioning, bed functionality, and overall comfort under KRIS implementation. Qualitative findings also extended the quantitative results by highlighting issues not directly captured by the HCAHPS dimensions, particularly perceived fairness under KRIS, limited room availability, prolonged waiting times, and the gap between patients' expectations and their actual experiences. Taken together, the findings suggest that patient satisfaction during KRIS implementation reflects an interaction between interpersonal aspects of care, the physical inpatient environment, service responsiveness, perceived fairness, and patients' expectations.

DISCUSSION

This study aimed to analyze inpatient satisfaction at a Semi-Urban Hospital. Quantitative results showed moderate satisfaction (overall 53.5%), with the highest ratings in doctor communication (80.3%) and the lowest in pain management (52.1%). Qualitative findings revealed that satisfaction was shaped by communication quality, empathy, environmental comfort, and perceived fairness in KRIS implementation. Integration of both datasets confirmed communication and responsiveness as key determinants of satisfaction. These findings align with global evidence indicating that provider communication and responsiveness are among the strongest predictors of satisfaction (Giordano et al., 2010; Manary et al., 2013). Effective communication fosters trust, emotional reassurance, and adherence, which are critical to patient experience (Doyle et al., 2013). In contrast, dissatisfaction in pain management and medication information mirrors trends in developing countries, where staff shortages and limited counseling time impede effective communication (Batbaatar et al., 2017).

Variable responsiveness reported that patients reported mixed experiences with staff responsiveness. Emergency responses were generally timely, but assistance for non-urgent needs was often delayed due to staffing constraints. Such findings are consistent with reports showing that delays in responsiveness can erode trust and perceived service quality (Bleich et al., 2009).

While KRIS was praised for ensuring equal room standards and care access, some respondents perceived disparities in attention between insured and paying patients. Regarding expectations and reality, satisfaction was heavily influenced by expectation management.

Combining quantitative and qualitative results revealed convergence on key determinants of satisfaction, particularly communication and responsiveness. Furthermore, the study highlights that satisfaction is context-dependent, shaped by both measurable service attributes and subjective perceptions. Integrating *HCAHPS* metrics with qualitative insights provided a nuanced understanding of how KRIS implementation influences patient experience in Indonesia's public hospital context.

Quantitative data identified the magnitude of satisfaction, while qualitative data explained why patients experienced satisfaction or dissatisfaction. However, there were some limitations. First, the cross-sectional design restricts causal interpretation between satisfaction determinants and patient experiences, as data were collected at a single point in time. Longitudinal research would provide better insights into how satisfaction changes across different stages of hospital care. Second, the study was conducted in one public hospital, which limits generalizability to other healthcare institutions, especially private or rural hospitals that may differ in infrastructure, staffing, and patient demographics.

CONCLUSION AND SUGGESTION

This study concludes that patient satisfaction at this hospital under the Standard Inpatient Class *(KRIS)* policy remains moderate, reflecting both achievements in equity and ongoing challenges in service quality. The results highlight that effective communication, empathy, and responsiveness are key aspects associated with satisfaction, whereas pain management and medication information require improvement. The mixed-method approach revealed that patient experience is shaped not only by structural reforms but also by interpersonal interactions and emotional engagement between patients and healthcare providers. These findings emphasize that achieving equitable healthcare access must be complemented by patient-centered practices that prioritize communication and compassion. To ensure sustainable improvements, hospitals should adopt continuous feedback systems, enhance staff capacity through training, and integrate satisfaction monitoring into accreditation and quality assurance frameworks. Strengthening these dimensions will advance Indonesia's goal of providing equitable, responsive, and high-quality hospital care for all citizens. This study demonstrates that structural equity alone, as achieved through KRIS, does not guarantee high patient satisfaction. Hospitals must complement infrastructure standardization with service excellence strategies emphasizing empathy, timeliness, and patient engagement. These findings highlight the potential value of strengthening patient satisfaction measurement within Indonesia's inpatient care system. As a potential future policy implication, the development of a standardized national patient satisfaction index informed by HCAHPS domains could be considered to facilitate benchmarking across hospitals

and support evidence-informed decision-making at the Ministry of Health level. Further multicenter and nationally representative studies are needed to assess the feasibility, validity, and policy relevance of such an approach before its broader implementation.

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