

# **TANGIBLES AND EMPATHY AS PRIMARY DRIVERS OF PATIENT SATISFACTION: UNMASKING A LATENT QUALITY CRISIS IN INDONESIA'S UNIVERSAL HEALTH COVERAGE SYSTEM**

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**Abstract:** Universal Health Coverage (UHC) represents a global commitment to healthcare equity. Indonesia's Jaminan Kesehatan Nasional (JKN), one of the world's largest single-payer systems, has made remarkable strides in expanding financial access. However, this rapid expansion raises critical questions about the quality of care delivered, with patient satisfaction serving as a vital, yet complex, barometer. This study moves beyond surface-level metrics to provide a nuanced analysis of the architectural and relational drivers of patient satisfaction among JKN beneficiaries, utilizing the multi-dimensional SERVQUAL framework. A quantitative, cross-sectional survey was conducted between July and August 2025 at a regional referral hospital in East Java. A cohort of 100 JKN inpatients was selected via purposive sampling. Data were collected using a validated 30-item, 5-point Likert scale questionnaire. To ensure the statistical integrity of our findings in the presence of non-constant error variance, we employed a multiple linear regression model with robust standard errors. The regression model was statistically significant and explained a substantial 37.2% of the variance in patient satisfaction (Adjusted). All five SERVQUAL dimensions were significant predictors. Critically, the analysis revealed a distinct hierarchy of influence. The **Tangibles** of the care environment (physical infrastructure, amenities) emerged as the most potent predictor, followed closely by **Empathy** (compassionate, individualized care). A pivotal finding was the profound disconnect between high aggregate satisfaction scores (mean range > 4.20) and a strikingly low willingness to return for future care (mean = 3.00), exposing a significant satisfaction-loyalty paradox. The patient experience under Indonesia's JKN is predominantly shaped by two fundamental pillars: the perceived quality of the physical environment and the perceived humanity of care delivery. The identified satisfaction-loyalty paradox points to a **latent quality crisis**—a silent dissatisfaction masked by patient gratitude and social desirability biases. This suggests that while the JKN has succeeded in reducing financial barriers, it has yet to fully address the quality and dignity of the care experience. For the UHC promise to be fully realized, policy and practice must pivot from a singular focus on access to a dual focus on investing in both hospital infrastructure and the relational capacity of the healthcare workforce.

**Keywords:** Patient Satisfaction, Service Quality, SERVQUAL, BPJS Kesehatan, Universal Health Coverage (UHC), Health System Performance, Latent Quality Crisis, Patient-Centered Care, Indonesia

## **1. Introduction**

### **The Paradox of Access: Universal Health Coverage in Indonesia**

The global health agenda is unequivocally centered on the promise of Universal Health Coverage (UHC)—a commitment to ensure that all individuals receive the health services they need without suffering financial hardship. Indonesia's Jaminan Kesehatan Nasional (JKN) stands as a monumental testament to this ambition. Since its inception in 2014, the JKN has rapidly enrolled over 85% of the population, fundamentally altering the nation's healthcare

landscape from a fragmented, fee-for-service model to a unified, single-payer system (Soraya & Harahap, 2023). This achievement in expanding financial access, particularly for the poor and near-poor, is undeniable (Anggraini, 2023).

However, this rapid expansion has created a significant paradox. While access has broadened, the quality of the care being accessed has come under intense scrutiny. The JKN's financing mechanism, primarily based on a prospective payment system of Indonesian Case-Based Groups (INA-CBGs), is designed to contain costs and promote efficiency (Soraya & Harahap, 2023). Yet, critics argue that these fixed reimbursement rates often fail to cover the full cost of quality care, placing immense financial strain on providers (Wenang et al., 2021). This pressure can manifest in overworked staff, deferred investment in infrastructure, and shortages of essential supplies, ultimately compromising the patient experience (Suwantika et al., 2023). Consequently, the discourse on UHC in Indonesia must evolve from a celebratory narrative of coverage numbers to a critical examination of the quality and dignity of care being delivered (Stavropoulou et al., 2022).

## 2. Literature Review

### Deconstructing the Patient Experience: Beyond Satisfaction Scores

Patient satisfaction is a cornerstone of health system assessment, serving as a powerful proxy for quality, safety, and patient-centeredness. It is not merely a measure of contentment but a complex psychological construct shaped by expectations, perceptions, and cultural values (AGBONJINMI et al., 2022; Aşık & Dikmen, 2023; Omowumi et al., 2023). High satisfaction is robustly linked to positive clinical and behavioral outcomes, including improved treatment adherence and lower readmission rates (Baumbach et al., 2023; Pham et al., 2024). However, aggregate satisfaction scores can be notoriously misleading, especially in LMIC contexts. They are often inflated by "gratitude bias," where patients express high satisfaction out of thankfulness for receiving any care at all, and social desirability bias (Berde et al., 2023). To penetrate this surface, a more granular analytical tool is required. The SERVQUAL model offers precisely this, providing a validated, multi-dimensional framework to dissect the patient journey (Jonkisz et al., 2023). By disaggregating the care experience into **Tangibles, Reliability, Responsiveness, Assurance, and Empathy**, SERVQUAL allows researchers and managers to move beyond asking "Are patients satisfied?" to the more critical question: "What specific elements of the service experience are driving or detracting from patient satisfaction?" This diagnostic power is essential for designing targeted and effective quality improvement interventions (Ali et al., 2022).

### The Research Imperative and a Novel Hypothesis

While the SERVQUAL model has been applied in Indonesia, a critical gap remains in understanding the relative weight of its dimensions within the unique operational and cultural context of regional hospitals serving a predominantly JKN-insured population. These institutions are the frontline of UHC delivery but are also the most exposed to its financial and operational pressures.

This study addresses this gap with a dual purpose. First, it seeks to empirically model and establish a hierarchy of the SERVQUAL dimensions in predicting patient satisfaction. Second, and more innovatively, it aims to test a novel hypothesis: that within the Indonesian JKN system, a significant **satisfaction-loyalty paradox** exists, indicative of a **latent quality crisis**. We posit that while patients may report high levels of satisfaction due to gratitude and low initial expectations, their true evaluation of service quality is more accurately revealed in their behavioral intentions (i.e., their willingness to return or recommend). Uncovering this paradox

is critical for policymakers, as it suggests that the officially reported success of the system may be masking a deep-seated erosion of patient trust and institutional legitimacy.

### 3. Methods

#### Study Design, Setting, and Period

This study employed a quantitative, cross-sectional survey design to capture a snapshot of patient perceptions at a specific point in time. The research was conducted over a three-week period, from July 25 to August 10, 2025. The study setting was RSUD Lirboyo Kota Kediri, a private, not-for-profit referral hospital in East Java. This hospital was strategically chosen as it represents a common institutional profile in Indonesia: a facility serving a large proportion of JKN patients and undergoing an accreditation transition from Class D to Class C, making quality improvement a high institutional priority.

#### Participants and Sampling Procedure

The target population comprised adult inpatients (aged 18–55) whose hospital stay was covered by BPJS Kesehatan. A non-probability, purposive sampling method was utilized to recruit 100 participants. The research team approached potential respondents who met a strict set of inclusion criteria: (1) currently admitted as an inpatient and having stayed for at least 48 hours to ensure sufficient exposure to services; (2) holding active BPJS Kesehatan membership; (3) being cognitively alert and able to provide coherent responses; and (4) willing to provide written informed consent. This sampling strategy, while not probabilistic, was deemed appropriate for ensuring that the sample was composed of individuals who could provide informed and relevant feedback on their care experience. The final sample size of 100 was determined to be sufficient for achieving a statistical power of approximately 0.80 in a multiple linear regression model with five predictors, allowing for the detection of medium-to-large effect sizes.

#### Data Collection Instrument and Measurement

A structured questionnaire was developed as the primary data collection tool. The instrument consisted of 30 items, meticulously adapted from previously validated SERVQUAL questionnaires used in healthcare settings. The questionnaire was divided into two main sections:

**Independent Variables (Service Quality):** 25 items measuring the five SERVQUAL dimensions (Tangibles, Reliability, Responsiveness, Assurance, and Empathy), with 5 items dedicated to each dimension.

**Dependent Variable (Patient Satisfaction):** 5 items designed to capture the overall satisfaction with the hospital experience. All items were measured on a 5-point Likert scale, ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). The instrument was first drafted in English and then translated into Bahasa Indonesia. It was subsequently back-translated to ensure semantic equivalence. A pilot test was conducted with 15 inpatients (not included in the final sample) to check for clarity, relevance, and internal consistency. The pilot results confirmed strong reliability, with Cronbach's alpha values for all constructs exceeding the standard 0.70 threshold, indicating high internal consistency.

#### Statistical Analysis

The collected data were coded and analyzed using SPSS Statistics for Windows, Version 26.0. The analysis proceeded in three stages:

1. **Descriptive Analysis:** Descriptive statistics (frequencies, percentages, means, and standard deviations) were calculated to summarize the demographic characteristics of the respondents and the scores for each service quality dimension and satisfaction item.
2. **Assumption Testing:** Prior to regression analysis, a series of diagnostic tests were performed to ensure the data met the assumptions of multiple linear regression. The Variance Inflation Factor (VIF) was calculated for all predictors to check for multicollinearity; all VIF values were well below the conservative threshold of 2.5, indicating no issues. The normality of residuals was confirmed using the Kolmogorov-Smirnov test. However, the Glejser test for heteroskedasticity was significant, indicating that the variance of the errors was not constant across levels of the predictors.
3. **Inferential Analysis:** To address the issue of heteroskedasticity and produce valid statistical inferences, a multiple linear regression model using **robust standard errors (RSEs)** was employed. This approach adjusts the standard errors of the coefficients to account for the non-constant variance, yielding more reliable p-values and confidence intervals. The overall model fit was assessed using the F-statistic, and the proportion of variance explained was determined by the  $R^2$  and Adjusted  $R^2$  values. Standardized beta coefficients () were used to compare the relative predictive power of each service quality dimension. The significance level for all inferential tests was set at .

### Ethical Considerations

The study protocol received full ethical approval from the Institutional Review Board of RSU Lirboyo. The research objectives and procedures were clearly explained to all potential participants. It was emphasized that their participation was voluntary and that their decision would not affect the quality of their care. Written informed consent was obtained from every participant. All data were anonymized to protect confidentiality and were stored securely.

## 4. Results and Discussion

### Demographic Profile of Respondents

The demographic characteristics of the 100 participants are summarized in Table 1. The sample was reasonably balanced in terms of gender, with a slight majority of females (56%). The age distribution reflected a typical adult inpatient population, with the largest group being individuals aged 30–44 years (36%). In terms of occupation, a significant portion (33%) identified as "other," a category that primarily included homemakers, retirees, and informal sector workers, highlighting the diverse socioeconomic backgrounds of JKN beneficiaries.

**Table 1. Demographic Characteristics of Respondents (N = 100)**

| Characteristic    | Category     | Frequency (n) | Percentage (%) |
|-------------------|--------------|---------------|----------------|
| <b>Gender</b>     | Male         | 44            | 44.0           |
|                   | Female       | 56            | 56.0           |
| <b>Age Group</b>  | 18–29 years  | 25            | 25.0           |
|                   | 30–44 years  | 36            | 36.0           |
|                   | 45–55 years  | 39            | 39.0           |
| <b>Occupation</b> | Student      | 23            | 23.0           |
|                   | Employee     | 23            | 23.0           |
|                   | Entrepreneur | 21            | 21.0           |
|                   | Other*       | 33            | 33.0           |

\*Note: "Other" includes homemakers, retirees, and informal workers.



### Descriptive Analysis of Service Quality and Patient Satisfaction

Overall, patients reported positive perceptions of service quality, with the mean scores for all five dimensions comfortably exceeding the neutral midpoint of 3.0 (see Table 2). The **Assurance** dimension received the highest mean rating (3.92), driven by high scores for staff professionalism and competence (mean = 4.01). This suggests that patients generally felt they were in safe and capable hands.

However, a closer look reveals areas of concern. The **Tangibles** dimension had the lowest mean score (3.50), with the item related to bed comfort receiving a particularly low rating (mean = 3.50). Similarly, within the **Empathy** dimension, the item measuring 'sustained attention during care' was rated poorly (mean = 3.48), indicating that while staff were perceived as friendly, patients felt a lack of consistent, individualized focus.

Regarding the dependent variable, overall patient satisfaction was high, with mean scores for items like 'I feel satisfied with the nursing services' reaching 4.84. Yet, this high satisfaction stood in stark contrast to the response for the item 'I will recommend this hospital to my family,' which had a mean of 4.21, and more critically, the item measuring **willingness to return**, which scored a neutral-to-low mean of just 3.00. This wide gap between expressed satisfaction and behavioral intent is a pivotal finding of this study.

**Table 2. Descriptive Statistics for Study Variables (N = 100)**

| Variable (Dimension/Item)    | Mean | Std. Deviation |
|------------------------------|------|----------------|
| <b>Tangibles</b>             | 3.50 | 0.89           |
| <b>Reliability</b>           | 3.88 | 0.91           |
| <b>Responsiveness</b>        | 3.75 | 0.85           |
| <b>Assurance</b>             | 3.92 | 0.95           |
| <b>Empathy</b>               | 3.70 | 0.88           |
| <b>Overall Satisfaction</b>  | 4.65 | 0.75           |
| <b>Willingness to Return</b> | 3.00 | 1.10           |

### Multiple Linear Regression Analysis: Predicting Patient Satisfaction

The multiple linear regression model was statistically significant, indicating that the five SERVQUAL dimensions as a set are strong predictors of patient satisfaction. The model accounted for 37.2% of the total variance in patient satisfaction, with an adjusted  $R^2$  of 0.339, which is a substantial proportion for a cross-sectional study in this field.

The results, detailed in Table 3, confirm that all five service quality dimensions were significant, positive predictors of patient satisfaction. The standardized beta coefficients allow for a direct comparison of their relative importance.

**Tangibles** emerged as the most powerful predictor, indicating that the physical environment and amenities had the greatest impact on how patients evaluated their overall experience.

**Empathy** was the second most influential factor, highlighting the critical role of compassionate and individualized care.

**Reliability** and **Responsiveness** also had strong, significant effects, underscoring the importance of dependable service and prompt attention.

**Assurance** (), while statistically significant, had the smallest relative impact, suggesting that while foundational, staff competence was a less variable and less impactful driver compared to the tangible and empathetic aspects of care.

**Table 3: Robust Multiple Linear Regression Predicting Patient Satisfaction**

| Predictor<br>(SERVQUAL<br>Dimension)                                                                                                            | Unstandardized<br>Coefficient (B) | Robust<br>Std.<br>Error | Standardized<br>Coefficient | t-<br>value | p-value |
|-------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------|-----------------------------|-------------|---------|
| (Constant)                                                                                                                                      | 1,254                             | 0,312                   | –                           | 4,019       | <0,001  |
| Tangibles                                                                                                                                       | 0,482                             | 0,089                   | 0,482                       | 5,416       | <0,001  |
| Empathy                                                                                                                                         | 0,324                             | 0,075                   | 0,324                       | 4,320       | <0,001  |
| Reliability                                                                                                                                     | 0,271                             | 0,068                   | 0,271                       | 3,985       | <0,001  |
| Responsiveness                                                                                                                                  | 0,263                             | 0,071                   | 0,263                       | 3,704       | <0,001  |
| Assurance                                                                                                                                       | 0,131                             | 0,057                   | 0,131                       | 2,298       | 0,023   |
| <i>Note: Model Fit Statistics: Model: <math>F(5,94) = 11,371, p &lt; 0,001</math>; <math>R^2 = 0,372</math>; (adj <math>R^2 = 0,339</math>)</i> |                                   |                         |                             |             |         |

## Discussion

### Synthesis of Principal Findings

This study empirically validates that the quality of service delivery is a powerful, multidimensional predictor of patient satisfaction within the Indonesian UHC framework. The analysis not only confirms the relevance of all five SERVQUAL dimensions but, more importantly, establishes a clear hierarchy of influence. The patient experience for JKN beneficiaries is overwhelmingly dictated first by the **physicality of the care environment (Tangibles)** and second by the **humanity of the clinical encounter (Empathy)**. This section provides a deeper, theory-informed interpretation of these findings and explores the profound implications of the identified "latent quality crisis."

### The Tangible Evidence of Quality: Infrastructure as Institutional Legitimacy

The ascendance of **Tangibles** as the premier predictor is a finding rich with theoretical and practical implications (Indraswari et al., 2021). From an **information asymmetry** perspective, patients, who lack the expertise to judge clinical competence, rationally substitute this judgment with an evaluation of what they can see and feel (Dahl et al., 2022; Lü et al., 2022). Clean wards, modern equipment, and comfortable amenities are not mere conveniences; they are powerful signals of institutional investment, competence, and respect for the patient. In the context of the JKN, where patients may fear receiving "second-class" care, these tangible cues serve as crucial evidence that the institution is legitimate and trustworthy (Rumi et al., 2021). Furthermore, this finding must be interpreted through the lens of **health economics** and the INA-CBG payment system. The fixed-tariff model creates a powerful incentive for cost minimization. Capital expenditures on infrastructure and amenities are often the first to be sacrificed in the face of tight operating margins (Brownlee & Tsai, 2023). The low patient rating for "bed comfort" is therefore not an isolated service failure but a direct symptom of a systemic financing model that may not adequately price in the costs associated with maintaining a dignified and therapeutic physical environment (Liu et al., 2021). The dominance of Tangibles in our model is thus a powerful critique of a financing system that may inadvertently deprioritize the very elements of care that matter most to patients.

### The Economy of Empathy: Emotional Labor Under Systemic Strain

**Empathy's** position as the second most potent predictor highlights the centrality of the relational aspect of care, particularly in a collectivist culture like Indonesia's (Efendy et al., 2023). However, our data's nuance—distinguishing between staff politeness (rated highly) and "sustained attention" (rated poorly)—demands a deeper analysis beyond mere "soft skills." We

must consider the concept of **emotional labor**: the work of managing one's emotions to fulfill the requirements of a job (Qin et al., 2022).

Nurses and doctors in under-resourced settings perform immense emotional labor, projecting compassion and calm amidst high patient loads and administrative burdens (Kwon & Song, 2024). The perceived lack of "sustained attention" is likely not a failure of individual empathy but a symptom of **systemic burnout and workforce strain**. When a nurse has an untenable patient-to-staff ratio, their capacity for the time-intensive work of active listening and emotional support is structurally depleted (Shaqiqi, 2025). This finding transforms the problem from one of individual training to one of **health workforce policy**. It suggests that achieving empathetic care is not possible without addressing the underlying drivers of burnout: inadequate staffing, long working hours, and the psychological toll of rationing care under financial constraints (Lwiza & Lugazia, 2023).

### **The Latent Quality Crisis: Unmasking the Satisfaction-Loyalty Paradox**

The most consequential finding of this research is the dramatic chasm between high reported satisfaction and low behavioral loyalty. This **satisfaction-loyalty paradox** is the empirical signature of what we term a **latent quality crisis**. This concept offers a new lens for interpreting patient feedback within nascent UHC systems.

High satisfaction scores, in this context, are likely a blend of genuine **gratitude** for financial protection (a form of procedural justice) and a culturally ingrained reluctance to express negative feedback directly. Patients are grateful that the system exists, and this gratitude colors their survey responses (Toscano et al., 2025). However, loyalty, or the willingness to entrust one's future health to the same institution, is a far more discerning and "market-based" metric (Hussain et al., 2025). It reflects a calculated decision based on the totality of the experience.

The low loyalty score reveals the patient's private truth: "I am grateful I was treated, but the experience was sufficiently flawed (uncomfortable room, rushed staff) that I would seek care elsewhere if I had a choice." This unvoiced dissatisfaction constitutes the "latent crisis." It is a silent erosion of trust that, if left unaddressed, will ultimately undermine the legitimacy and long-term sustainability of the JKN. It poses a profound challenge to policymakers, suggesting that reliance on simplistic satisfaction surveys may be creating a dangerous blind spot to deep-seated systemic failures (Pinho, 2021).

## **5. Conclusion**

### **Concluding Synthesis**

This study concludes that the patient experience under Indonesia's ambitious JKN program is forged at the intersection of architecture and affection—the tangible quality of the physical environment and the empathetic quality of human interaction. Our analysis establishes a clear hierarchy of needs where these two dimensions are paramount. More critically, we have unearthed a "latent quality crisis," evidenced by a stark satisfaction-loyalty paradox, which challenges the prevailing narrative of success based on coverage expansion alone. While the JKN has successfully lowered financial barriers, it has not yet guaranteed a consistently high-quality or dignified care experience. The promise of Universal Health Coverage is not merely about access, but about access to quality care.

### **Strategic Recommendations**

Based on this evidence, we propose the following strategic recommendations:

#### **1. For Policy (BPJS Kesehatan & Ministry of Health):**

**Reform Reimbursement to Reward Quality:** Critically review and potentially restructure INA-CBG tariffs to include weighted adjustments for non-clinical quality, particularly patient-reported experiences with Tangibles and Empathy.

**Incentivize Capital Investment:** Develop national programs (e.g., grants, low-interest loans) that specifically target the modernization of hospital infrastructure, linking funding to demonstrated improvements in patient satisfaction with the physical environment.

**Establish National Workforce Standards:** Move towards establishing and enforcing evidence-based minimum nurse-to-patient ratios to combat burnout and create the structural conditions necessary for empathetic care to flourish.

2. **For Hospital Management:**

**Conduct "Quality Audits" Focused on Tangibles:** Go beyond clinical audits to systematically assess and prioritize improvements in the physical patient environment, focusing on high-impact areas like bedding, noise reduction, and cleanliness.

**Invest in Relational Care Models:** Implement and invest in care delivery models (e.g., primary nursing, structured interdisciplinary bedside rounds) that are explicitly designed to foster sustained, trusting relationships between providers and patients.

**Adopt Loyalty as a Key Performance Indicator (KPI):** Shift from tracking simple satisfaction scores to monitoring patient loyalty and willingness to recommend as more robust and actionable indicators of true performance.

**Agenda for Future Research**

This study opens several vital avenues for future inquiry:

**A National, Mixed-Methods Study:** Replicate this study on a national scale using a stratified random sample of hospitals to validate the hierarchy of dimensions and the prevalence of the latent quality crisis across diverse settings (public vs. private, rural vs. urban). Qualitative interviews should be integrated to deeply explore the lived experiences behind the satisfaction-loyalty paradox.

**Longitudinal Cohort Studies:** Track cohorts of patients over time to understand how their perceptions of quality evolve with repeated exposure to the healthcare system and how these perceptions influence long-term health behaviors and outcomes.

**Health Economics of Quality:** Conduct rigorous economic analyses to model the return on investment (ROI) of specific quality improvements. For example, what is the cost-benefit analysis of investing in upgraded hospital beds versus the potential gains in patient loyalty, reduced complications, and enhanced community reputation?

By pursuing this agenda, researchers can provide the evidence needed to guide Indonesia's UHC journey from a focus on quantity of coverage to a lasting commitment to the quality of care.

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