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SERVICE QUALITY AND HOSPITAL FACILITIES AS DRIVERS OF PATIENT SATISFACTION IN NATIONAL HEALTH INSURANCE SERVICES

Suhardoyo[1]*, A. Sudrajat[2], Isyana Emita [3], Roydawati Bunga Sihol[4], Siti Hoerunnisa[5]

[1,2,3,4,5]Faculty of Economics, Universitas Bina Sarana Informatika, Indonesia

[1] suhardoyo.syo@bsi.ac.id, [2] asudrajat.aut@bsi.ac.id,

[3]isyana.iea@bsi.ac.id, [4] roydawaty.obs@bsi.ac.id

[5]hoerunnisa65@gmail.com

*Corresponding Author

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Abstract

Patient satisfaction is an important outcome of healthcare service management because it reflects how patients evaluate the care environment and service processes they experience. Within Indonesia's National Health Insurance (BPJS Kesehatan) system, hospitals must manage both service delivery and the physical conditions that support inpatient care. This study examines the association of service quality and hospital facilities with patient satisfaction among BPJS inpatients. A quantitative cross-sectional design was employed using questionnaire data from 100 BPJS inpatients. Service quality was measured through the SERVQUAL dimensions of tangibles, reliability, responsiveness, assurance, and empathy, while hospital facilities represented the adequacy and condition of physical and supporting resources. Multiple linear regression was employed to examine the partial and joint associations of the two predictors with patient satisfaction. The findings show that service quality is positively and significantly associated with patient satisfaction (B = 0.424, p = 0.001), while hospital facilities also show a positive and significant association (B = 0.346, p = 0.026). The joint regression model is statistically significant (F = 28.683, p = 0.001), with an adjusted R^2 of 0.359, indicating that the two predictors explain 35.9% of the variation in patient satisfaction in the study sample. The findings suggest that patient satisfaction is multidimensional and is also influenced by factors beyond the two predictors examined. The study contributes empirical evidence on the combined role of service delivery and the physical care environment in the BPJS inpatient context. For hospital managers, the findings highlight the importance of integrating responsive, reliable, and empathetic service with continuous attention to cleanliness, safety, comfort, accessibility, and functional inpatient facilities.

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INTRODUCTION

Patient satisfaction is increasingly treated as an outcome of healthcare quality rather than as a simple indicator of whether patients feel pleased with a service encounter. In healthcare, satisfaction reflects patients' evaluations of clinical and non-clinical experiences, including communication, accessibility, responsiveness, reliability, and the physical environment in which care is delivered. Systematic evidence shows that satisfaction research has expanded across multiple dimensions of healthcare experience and that medical care, communication, and patient characteristics remain important

explanatory domains (Ferreira et al., 2023)(Abdalla & Pavlova, 2023). The quality of care perspective also emphasizes that healthcare outcomes are produced through interactions between structures, processes, and outcomes rather than through isolated service activities (Rauf et al., 2024)(Aboueldahab et al., 2025).

Service quality is therefore a central management concern in hospitals. SERVQUAL established five widely used dimensions—tangibles, reliability, responsiveness, assurance, and empathy—for evaluating perceived service quality (Kratochvil, 2025)(Parasuraman et al., 1988). Later work has shown that healthcare service quality is more complex than a simple transfer of generic service-quality models because healthcare contains technical, interpersonal, administrative, environmental, and outcome-related components (Tobari et al., 2025)(Yunus et al., 2025). Recent systematic reviews similarly identify SERVQUAL as an influential framework while emphasizing healthcare facility administration, patient attributes, servicescape, and the physical environment as additional dimensions that shape perceived quality (Çelik & Bölükbaşı, 2026).

Patient satisfaction can be understood through expectation-disconfirmation logic: patients compare experienced performance with expectations and form an overall evaluation of the service encounter (Schiebler et al., 2025). This perspective is especially relevant to inpatient care because patients experience the service over an extended period and interact repeatedly with nurses, physicians, administrative staff, pharmacy personnel, and other support functions. Service quality can consequently affect satisfaction through both functional interactions and the consistency of service delivery (Husaeni et al., 2026)(Helmiatin, 2013). Empirical evidence from public hospitals also shows that patient experience and perceived quality are closely related, although the strength of particular dimensions can differ across settings (Guzmán-leguel, 2025)(Hermansyah et al., 2026).

Hospital facilities constitute a second managerial dimension. Physical surroundings are not merely passive infrastructure; they can influence perceptions, emotions, comfort, and behavioral responses in service settings (Tian, 2023). In healthcare, environment quality and tangible attributes are incorporated into broader models of health service quality (Agarwal et al., 2022). Research on hospital servicescape has associated physical characteristics such as cleanliness, aesthetics, convenience, amenity, and accessibility with patient evaluations (An et al., 2023)(Hajjar et al., 2016). Recent research further demonstrates that the hospital built environment can affect treatment satisfaction, indicating that physical conditions should be considered part of the patient experience rather than a purely operational issue (Du et al., 2026)(Weber et al., 2022).

In Indonesia, the BPJS Kesehatan program creates a distinctive service-management context because hospitals must serve large numbers of participants within a national insurance system. Recent studies show that BPJS patient satisfaction is related to service quality, although the strength of specific dimensions varies across settings (Pangaribuan et al., 2025)(Purnama et al., 2025). Research in Indonesian public hospitals also identifies differences in patient satisfaction across inpatient classes and dimensions such as accessibility, effectiveness, patient-centeredness, and equity(Alysia et al., 2025). Studies of Indonesian hospitals have further reported relationships between service quality and satisfaction among BPJS patients in inpatient and outpatient settings (Ferdy Toway Rumambi et al., 2025)(Kamalo et al., 2024).

Despite this growing evidence, a contextual and conceptual gap remains. Much of the Indonesian BPJS literature evaluates service quality as a single predictor or examines individual SERVQUAL dimensions, while fewer studies place service quality and the physical hospital environment in the same explanatory model for inpatient satisfaction. This distinction matters because patients do not experience service interactions independently from the physical environment: a responsive service process may be undermined by poor cleanliness or inadequate facilities, while good facilities may not compensate for unreliable or insensitive service. Recent systematic reviews reinforce the need to consider multiple dimensions of healthcare quality and patient experience together(Rahmatia et al., 2024) (Mrp et al., 2025)(Zehra et al., 2024).

The present study therefore focuses on the joint role of service quality and hospital facilities in explaining BPJS inpatient satisfaction. Its contribution is empirical rather than a claim of a new universal theory: it integrates functional service delivery and the physical care environment within an Indonesian national health insurance context and translates the results into hospital-management implications. The research asks whether service quality affects patient satisfaction, whether hospital facilities affect patient satisfaction, and whether the two predictors jointly explain meaningful variation in satisfaction.

RESEARCH METHODS

Research Design

This study used a quantitative, cross-sectional design. The original manuscript reports that data were collected through questionnaires from 100 BPJS inpatients and analyzed using validity testing, reliability testing, classical assumption testing, multiple linear regression, t-tests, F-tests, and the coefficient of determination. The analytical model was specified as: $Y = \beta0 + \beta1X1 + \beta2X2 + \varepsilon$, where Y denotes patient satisfaction, X1 denotes service quality, X2 denotes hospital facilities, and ε denotes the error term.

Population, Sample, and Sampling

The target population comprised BPJS Kesehatan participants receiving inpatient services at RSUD dr. Chasbullah Abdulmadjid Bekasi. Based on the documented respondent characteristics in the original study, the inclusion criteria were: (1) BPJS Kesehatan patients receiving inpatient services at the study hospital; (2) respondents aged 17 years or older; (3) respondents who were able to understand and complete the questionnaire; and (4) respondents who voluntarily agreed to participate. Respondents who did not meet these eligibility requirements or did not provide a complete questionnaire were excluded from the analytical sample. The respondent profile confirms that the 100 respondents included in the study were distributed across age groups beginning at 17 years: 17–25 years (20 respondents), 26–35 years (22), 36–49 years (18), and above 50 years (40). The minimum sample size was determined using the Lemeshow formula because the target population was considered large and its exact size was not specified. The parameters used were Z = 1.96 for a 95% confidence level, p = 0.50 as the maximum estimated proportion, and d = 0.10 as the sampling error (10%). Thus, $n = [Z^2 \times p(1 - p)] / d^2 = [(1.96)^2 \times 0.50 \times 0.50] / (0.10)^2 = 96.04$. The minimum sample was therefore 96 respondents, and the study subsequently used 100 respondents.

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Data Collection and Measurement

Data were collected through a structured questionnaire. The manuscript identifies three constructs: service quality (X1), hospital facilities (X2), and patient satisfaction (Y). The original validity tables contain ten questionnaire items for each construct. The instrument used a Likert-type response format; the exact anchor wording and the source/adaptation of each item should be stated in the final submission based on the original questionnaire. The operationalization is summarized below.

Table 1. Operationalization of the study variables

Variable	Conceptual definition	Operational dimensions/items	Scale
Service quality (X1)	Patients' evaluation of how reliably and responsively hospital services are delivered.	Tangibles, reliability, responsiveness, assurance, empathy; 10 questionnaire items as reported in the original manuscript.	Likert
Hospital facilities (X2)	Patients' evaluation of the adequacy, cleanliness, safety, comfort, and functionality of supporting hospital facilities.	Physical and supporting facility attributes; 10 questionnaire items as reported in the original manuscript.	Likert
Patient satisfaction (Y)	Overall evaluation of the inpatient service experience relative to expectations.	Satisfaction with the received inpatient service; 10 questionnaire items as reported in the original manuscript.	Likert

Validity and Reliability

Item validity was assessed by comparing item-total correlation coefficients with the reported critical value of 0.195. All listed items exceeded that threshold in the original analysis. Reliability was evaluated using Cronbach's alpha. Cronbach's alpha should not be interpreted as a universal pass/fail statistic; its magnitude depends on the number of items, construct dimensionality, and item covariance (Aprianti et al., 2025). Because the original alpha coefficients were relatively low, the revised manuscript reports them transparently rather than simply labeling them as strongly reliable.

Classical Assumption Tests and Regression

Before conducting multiple linear regression, the study assessed the relevant classical assumptions, including normality, multicollinearity, and heteroskedasticity. Normality was assessed using the Kolmogorov–Smirnov test, while multicollinearity was evaluated using tolerance and variance inflation factor (VIF). Heteroskedasticity was assessed using the Glejser test by regressing the absolute values of the regression residuals on the independent variables. A significance level of 5% ($\alpha = 0.05$) was used. A p-value greater than 0.05 indicates no statistically significant evidence of heteroskedasticity. Based on the verified 100-case respondent tabulation, the Glejser test yielded p-values of 0.598 for service quality (X1) and 0.148 for hospital facilities (X2).

Hypothesis testing used a 5% significance level. The t-test evaluated the partial effect of each predictor, the F-test evaluated the joint contribution of the predictors, and adjusted R^2 was used to describe the proportion of variation in satisfaction explained by the model after accounting for model complexity.

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RESULTS AND DISCUSSION

Respondent Profile

The original study included 100 respondents. Female respondents represented 55% of the sample and male respondents 45%. The largest age category was respondents above 50 years (40%), followed by 26–35 years (22%), 17–25 years (20%), and 36–49 years (18%). These characteristics are presented only as sample description and are not used as explanatory variables in the hypothesis model.

Table 2. Respondent profile

Characteristic	Category	n	%
Gender	Male	45	45
Gender	Female	55	55
Age	17–25 years	20	20
Age	26–35 years	22	22
Age	36–49 years	18	18
Age	>50 years	40	40

Validity and Reliability Results

All questionnaire items reported in the original validity tables exceeded the stated critical correlation of 0.195. This supports the authors' original claim that the retained items were statistically associated with their intended construct. The reliability coefficients were 0.570 for service quality, 0.661 for hospital facilities, and 0.550 for patient satisfaction. These values should be interpreted cautiously because they are below the commonly preferred 0.70 level for established scales. Cronbach's alpha is influenced by item number and inter-item covariance, so the final manuscript should report the instrument's development history and, ideally, item-level diagnostics before making a strong reliability claim (Tavakol & Dennick, 2011).

Table 3. Reliability results

Construct	Cronbach's alpha	Interpretation in revision
Service quality (X1)	0.570	Relatively low; requires cautious interpretation
Hospital facilities (X2)	0.661	Moderate; below the commonly preferred 0.70 benchmark
Patient satisfaction (Y)	0.550	Relatively low; requires cautious interpretation

Classical Assumption Results

The normality test reported an Asymp. Sig. (2-tailed) value of 0.246, which is greater than 0.05. Multicollinearity was assessed using tolerance and VIF values. The heteroskedasticity test was then conducted using the Glejser procedure. The test produced a p-value of 0.598 for service quality (X1) and 0.148 for hospital facilities (X2). Because both values exceed the 0.05 significance threshold, the model shows no statistically significant evidence of heteroskedasticity. Therefore, the homoscedasticity assumption is considered satisfied.

Multiple Regression and Hypothesis Testing

The reported regression equation is Y = 8.661 + 0.424X1 + 0.346X2 + ε. The positive coefficients indicate that higher perceived service quality and better perceived hospital facilities are associated with higher patient satisfaction, holding the other predictor constant.

Table 4. Regression and hypothesis-testing results

Predictor	Coefficient (B)	t	p	Decision
Service quality (X1)	0.424	3.331	0.001	Supported
Hospital facilities (X2)	0.346	2.262	0.026	Supported
Joint model	—	F = 28.683	0.001	Supported

Effect of Service Quality on Patient Satisfaction

Service quality has a positive and statistically significant association with patient satisfaction (B = 0.424, p = 0.001). The managerial meaning of this result is broader than simply stating that service quality is significant. In inpatient care, patients repeatedly encounter service personnel and administrative processes, so reliability and responsiveness can shape their assessment of whether the hospital is organized, dependable, and attentive. This interpretation is consistent with the broader health-service-quality literature, which identifies interpersonal, technical, administrative, and environmental components as relevant to perceived quality (Putra et al., 2026)(Bentum-Mica et al., 2020). It is also consistent with empirical work showing that service quality predicts satisfaction in hospital and public-health settings (Edward & Mahrani, 2026)(Nu'man et al., 2024).

In the BPJS context, service quality has an additional governance dimension. Patients are not evaluating only clinical encounters; they also experience registration, information, coordination, communication, and the perceived certainty of service procedures. Recent BPJS-focused studies indicate that the relationship between service quality and satisfaction is generally positive but not uniform across dimensions and service settings (Sudirman et al., 2026)(Yulianti & Harmawan Teguh Saputra, 2026). Therefore, hospital managers should monitor service quality at process level rather than rely solely on an overall satisfaction score.

Practical priority should be given to clear communication, predictable procedures, responsiveness to patient requests, respectful interaction, and consistent information about inpatient requirements. These measures are particularly relevant where patients depend on an insurance system and may have limited control over administrative processes. The result therefore supports service-quality improvement as a core part of BPJS inpatient management rather than treating patient satisfaction as a separate downstream issue.

Effect of Hospital Facilities on Patient Satisfaction

Hospital facilities also have a positive and statistically significant association with patient satisfaction (B = 0.346, p = 0.026). This finding supports the argument that the physical environment is part of the service experience. Bitner's servicescape framework explains how physical surroundings can shape customer responses, while healthcare-

specific models place environment quality and tangibles alongside interpersonal, technical, and administrative dimensions (Honesta et al., 2025). Research on hospital servicescapes similarly indicates that cleanliness, aesthetics, convenience, amenity, and accessibility can influence patient evaluations (Rahman et al., 2025).

The finding is also compatible with Indonesian evidence. Studies of hospital facilities in Indonesia have reported positive relationships with patient satisfaction, while research in public hospitals has emphasized the importance of accessibility, patient-centeredness, equity, and the physical environment in patient evaluations (Sudirman et al., 2025). The implication is that facility management should not be separated from service-quality governance(Meher & Zaluchu, 2025).

For BPJS inpatients, facility priorities include cleanliness, sanitation, bed and room condition, safety, accessibility, equipment availability, and comfort. These attributes are visible and repeatedly experienced throughout an inpatient stay. Accordingly, preventive maintenance and routine environmental audits should be integrated into patient-experience management. A facility can be technically available but still generate dissatisfaction when it is poorly maintained, difficult to access, or inconsistent with patients' expectations.

Simultaneous Effect and the Meaning of Adjusted R^2

The F-test indicates that service quality and hospital facilities jointly explain a statistically significant portion of variation in patient satisfaction ($F = 28.683$, $p = 0.001$). This result is substantively important because the two predictors represent complementary aspects of healthcare delivery: service quality captures how the service is delivered, whereas facilities capture the physical and supporting conditions in which that service is experienced. The joint effect is therefore consistent with an integrated patient-experience perspective rather than two unrelated determinants.

The adjusted R^2 of 0.359 indicates that the two predictors explain 35.9% of the variation in patient satisfaction in the reported sample, while approximately 64.1% remains associated with other determinants outside the model. This should not be interpreted as evidence that the model is invalid. Patient satisfaction is multidimensional and can also be shaped by waiting time, perceived accessibility, trust, communication, clinical outcomes, administrative convenience, expectations, perceived fairness, and other elements of patient experience (Ferreira et al., 2023)(Abdalla & Pavlova, 2023). The value instead suggests that service quality and facilities are meaningful but incomplete components of satisfaction.

From a governance perspective, the result supports a coordinated improvement system. Hospital management should avoid improving staff responsiveness while neglecting the inpatient environment, or investing in facilities without improving communication and reliability. Quality improvement should therefore combine service-process indicators with facility-condition indicators and patient feedback. This integrated approach is also consistent with recent reviews that identify healthcare facility administration and servicescape as important dimensions alongside conventional SERVQUAL constructs (Rauf et al., 2024).

Table 5. Managerial implications

Finding	Managerial implication
Service quality positively predicts satisfaction	Strengthen responsiveness, reliability, assurance, empathy, and information clarity.
Hospital facilities positively predict satisfaction	Prioritize cleanliness, safety, comfort, accessibility, maintenance, and functional equipment.
Joint model significant	Integrate service-process monitoring and facility management rather than managing them separately.
Adjusted $R^2 = 0.359$	Expand future models with waiting time, trust, accessibility, communication, outcomes, and other patient-experience variables.

Integrated Managerial Implications

The findings support an integrated approach to hospital service management in which frontline service delivery and the physical care environment are governed as interconnected components of patient experience. The positive association between service quality and satisfaction indicates that hospital managers should monitor the reliability, responsiveness, assurance, empathy, and tangible aspects of service encounters. At the same time, the positive association between facilities and satisfaction indicates that environmental conditions can either reinforce or weaken the value created through interpersonal service. This is consistent with healthcare-quality models that treat technical, interpersonal, administrative, and environmental dimensions as related rather than isolated elements(Hassija et al., 2024).

A practical governance implication is the development of a joint patient-experience dashboard. Service indicators may include response time, information clarity, complaint resolution, and consistency of procedures, while facility indicators may include room cleanliness, equipment availability, sanitation, safety, accessibility, and maintenance completion. Combining these indicators can help managers identify whether dissatisfaction is generated primarily by service processes, physical conditions, or their interaction. Recent evidence on BPJS service transformation also emphasizes accessibility, speed, and equity as important dimensions of service improvement(Naci Büyükkaraciğan, 2025).

The management response should also recognize the distinctive position of BPJS patients. Insurance-based care involves administrative rules and referral processes that can affect patients' perceptions even when clinical treatment is appropriate. Consequently, communication about procedures, entitlements, waiting processes, and inpatient requirements should be treated as part of service quality. Evidence from Indonesian health-insurance research suggests that service quality, insurance-system experience, and patient trust can jointly shape satisfaction and loyalty (Putra et al., 2026)(Alysia et al., 2025).

Finally, facility investment should be evaluated from the patient perspective rather than solely from technical compliance. A facility can meet an internal standard yet remain difficult to use, uncomfortable, or poorly communicated to patients. Routine patient-experience feedback can therefore complement technical inspections. This approach is

consistent with research emphasizing the multidimensional nature of patient experience and the importance of routine measurement for quality improvement (Ramos et al., 2026)(Abdalla & Pavlova, 2023).

CONCLUSION

This study demonstrates that patient satisfaction among BPJS inpatients is associated with both the functional quality of hospital services and the physical conditions supporting inpatient care. Service quality shows a positive and significant relationship with satisfaction, indicating that reliable, responsive, assured, and empathetic service delivery remains central to patients' evaluations. Hospital facilities also show a positive and significant relationship with satisfaction, reinforcing the view that cleanliness, safety, comfort, accessibility, and functional infrastructure are not secondary elements but visible components of the care experience.

The principal contribution of the study is the integration of service quality and hospital facilities within a national health insurance context. Rather than treating patient satisfaction solely as a consequence of staff–patient interaction, the study shows the value of considering the service process and physical environment together. For hospital management, the findings imply that quality improvement should be coordinated across frontline service delivery and facility management. Monitoring should combine patient feedback with operational indicators so that service responsiveness and physical conditions are improved simultaneously.

Several limitations should be acknowledged. First, the design is cross-sectional, limiting causal interpretation. Second, the study is based on a single hospital context and a reported sample of 100 respondents, which limits generalizability. Third, the model includes only two explanatory variables, leaving substantial variation in satisfaction unexplained. Fourth, the original reliability coefficients are relatively low and require cautious interpretation. Fifth, the original manuscript did not report a heteroscedasticity diagnostic, which should be completed before final resubmission. Future research should use larger multi-hospital samples, incorporate variables such as waiting time, trust, accessibility, communication, perceived fairness, clinical outcomes, and administrative experience, and consider longitudinal or mixed-method designs.

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Statement on AI Use

AI-assisted tools were used during manuscript revision for language polishing, structural editing, reviewer-response organization, and reference formatting support. The authors remain responsible for the accuracy of the research design, data, statistical results, interpretations, citations, and final submitted manuscript. No AI system was used to fabricate respondent data or statistical findings.

Conflicts of Interest

The authors declare that they have no conflict of interest related to the research, authorship, or publication of this article.

Author Contributions

All authors contributed to the conception and development of the study, data collection and/or analysis, interpretation of findings, manuscript preparation and critical revision, and approval of the final version. The authors should verify this statement against their actual contributions before submission.

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