COMPARATIVE ANALYSIS OF PUBLIC HEALTH SERVICE QUALITY BETWEEN JAPAN'S KOKUMIN KENKOU HOKEN AND INDONESIA'S BPJS KESEHATAN

Riza Adelia Suryani[1]

[1] Department of Public Administration, Sriwijaya University, South Sumatra, Indonesia

rizaadeliasuryani@fisip.unsri.ac.id
*corresponding author

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ABSTRACT

The purpose of this study is to compare the health service systems of Kokumin Kenkou Hoken (KKH) in Japan and BPJS Kesehatan in Indonesia as representations of developed and developing countries. The research problem focuses on the disparities in effectiveness, efficiency, and service quality resulting from differences in infrastructure, financing mechanisms, and technological adoption in both countries. The analysis is grounded in comparative public administration theory and the service quality framework proposed by Zeithaml et al. This study employs a qualitative method through an extensive literature review of regulations, official reports, and recent scholarly findings related to national health insurance systems. The results indicate that KKH outperforms in efficiency, technological integration, such as Electronic Medical Records (EMR) and sustainable financing supported by a 50% government subsidy, while BPJS continues to struggle with financing deficits, service inequality, and limited infrastructure despite adopting digital tools such as the Mobile JKN application and the VClaim system. The study recommends strengthening digital health infrastructure, improving public digital literacy, and enhancing international collaboration to support more inclusive and equitable health service delivery in Indonesia.

INTRODUCTION

Quality health services are a crucial element in ensuring public welfare. Both developed and developing countries face different challenges in managing national health insurance programs. Japan, as an advanced country, and Indonesia, as a developing nation, present an interesting comparison in the implementation of universal health coverage. Japan's Kokumin Kenkou Hoken (KKH) operates under the National Health Insurance Act and provides broad access not only for formal workers but also for informal and self-employed individuals. Foreign residents can also become participants by fulfilling administrative requirements, such as holding a resident card and registering at the local social security office (MHLW, 2021). Conversely, Indonesia's BPJS Kesehatan was formed

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based on Article 28H and Article 34 of the 1945 Constitution, aiming to cover all citizens, including foreign residents staying at least six months (Kemenkes, 2022).

Japan allocates 50% government subsidies for health spending, while participants pay 30% of medical costs through cost-sharing (OECD, 2022). In contrast, BPJS relies heavily on participant contributions determined by service class, and the system has faced repeated deficits (Bank, 2020). Despite these differences, both systems share similarities in the use of income-based premiums and technology integration to improve service delivery. Technological readiness constitutes a key differentiator. Japan has widely implemented EMR, big data, and AI in medical services, achieving more than 90% EMR adoption nationwide (OECD, 2022). Meanwhile, BPJS is developing digital services through Mobile JKN and VClaim, yet infrastructure limitations and low digital literacy remain significant barriers (Siregar et al., 2021).

Theoretical perspectives strengthen this analysis. According to (Otenyo & Lind, 2020), comparative public administration evaluates how policy frameworks operate across different cultural and socio-economic contexts. (Sinambela, 2021) asserts that public service must be aligned with governance principles, whereas (V. Zeithaml et al., 2018) emphasize the role of service quality dimensions in shaping user satisfaction. These theories help explain why Japan's system performs more efficiently than BPJS in terms of responsiveness, reliability, and technological integration. This study concludes that comparing KKH and BPJS provides critical insights for improving Indonesia's health insurance system, especially regarding digital infrastructure, governance reform, and policy sustainability.

The term "Comparison" contained in Comparative State Administration (PAN), Comparative State Administration (ANP), Comparative Public Administration, or other term terms, has the meaning of a process to study or understand the similarities and/or differences between institutions (institutions), symptoms, phenomena, processes, etc., that exist in/related to the discipline of State Administration to then carry out Benchmarking/Benchmarking Studies. Comparative State Administration is a branch of Public Administration to observe Government in various different cultural, social, and economic settings. The study covers a wide diversity in terms of activities, including public policy-making and its implementation in both developed and developing areas.

Meanwhile, the definition of State/Public Administration has been widely discussed by experts. In principle, this is an application/implementation of one of the dimensions of "administration" that emphasizes the discussion in the field of statehood, in the sense or scope of understanding both macro and micro. In general, the definition of Administration includes the following aspects: aspects of the maintenance process, aspects of cooperation carried out by more than one person, aspects of the strategy to achieve the goals that have been set.

According to Ontenyo and Lind (Otenyo & Lind, 2020), Comparative State Administration is a branch of Public Administration to observe Government in various different cultural, social, and economic settings. The study covers a wide diversity in terms of activities, including public policy-making and its implementation in both developed and developing areas.

Service is any activity that is profitable in a collective group, and offers satisfaction even though the results are not tied to a product physically (Sinambela, 2021). And according to (Hastono, 2008). Service is an activity or series of activities that are invisible (intangible) that occur as a result of interaction between consumers and employees or

other things provided by service providers that are intended to solve consumer/customer problems.

As stated by(Kusuma Atmaja, 2002) in his research, public service can be interpreted as providing services (serving) the needs of people or communities who have an interest in the organization in accordance with the main rules and procedures that have been set. Public service is defined as the provision of services (serving) the needs of people or communities who have an interest in the organization in accordance with the main rules and procedures that have been set. Furthermore, according to KEPMENPAN No. 63/KEP/M.PAN/7/2003), public services are all service activities carried out by public service providers as an effort to meet the needs of service recipients and the implementation of the provisions of laws and regulations.

Public services are all activities carried out by public service providers as an effort to meet public needs and implement the provisions of laws and regulations. In this case, what is meant by the implementation of public services is government agencies which include, (Mahmudi, 2010): First, work units/organizational units of the ministry. Second, the Department. Third, non-departmental government institutions. Fourth, the Secretariat is the highest and highest institution of the State. Fifth, State-Owned Enterprises. Sixth, State-Owned Legal Entities. Seventh, Regional-Owned Enterprises. Eighth, other government agencies, both central and regional, including agencies and agencies. Thus, public services are the fulfillment of the desires and needs of the community by State administrators. The state was established by the public, of course, with the aim of improving the welfare of the community.

Service quality is a form of consumer assessment of the level of service received with the expected level of service. Meanwhile, according to (Tjiptono & Chandra, 2011), service quality is a benchmark of how good the level of service provided and able to meet customer expectations. Meanwhile, according to Zeithaml, Parasuraman, and also Berry (Sunyoto, 2012), service quality is the customer's perception of the excellence of a service. Service quality can be concluded as a benefit that can be felt by consumers and is intangible. Based on the definition of these experts, service quality is the fulfillment of consumer needs based on the level of excellence of products and services that are in accordance with expectations so that they can meet the desires of consumers.

The quality of service will have an impact on consumer satisfaction, where every consumer wants the product or service produced by the manufacturer to be able to provide satisfaction to its consumers (Kotler & Armstrong, 2017). The quality of service is measured based on five dimensions known as TERRA, namely: reliability is the ability to provide services immediately; responsiveness, which is the desire of the staff to provide responsive service and help consumers to solve problems assurance includes knowledge, competence, courtesy and trustworthiness of employees; empathy is the attitude of employees who give sincere attention to their consumers; tangible evidence is the appearance of facilities and infrastructure, employees and other physical facilities (Tjiptono, 2018).

Effectiveness is basically related to the achievement of policy goals or targets (outcomes). Effectiveness is the relationship between output and goals and objectives that must be achieved. Operational activities are said to be effective if the activity process achieves the goals and final objectives of the policy (spending wisely). The effectiveness indicator describes the range of outcomes and impacts of the program's output in achieving program goals (Mardiasmo, 2009). Defines effectiveness as the relationship between

output and goals or can also be said to be a measure of how far the level of output, policies and procedures from the organization goes (Pekei, 2016).

The definition of efficiency is related to the concept of productivity. Efficiency measurement is carried out using a comparison between the output produced and the input used (cost of output). The process of operational activities can be said to be efficient if a certain product or work result can be achieved with the lowest use of resources and funds (spending well). Efficiency is the achievement of maximum output with a certain input or the use of the lowest input to achieve a certain output. Efficiency is a comparison of output/inputs that are associated with performance standards or targets that have been set. Stated that public sector organizations are considered more efficient if the efficiency ratio tends to be above one (Deddy & Ayuningtyas, 2010). The larger the ratio, the higher the efficiency level. Efficiency should be compared to a specific reference figure, such as the efficiency of the previous period or efficiency in other public sector organizations.

It can be concluded that Effectiveness emphasizes the achievement of program objectives by assessing the relationship between outputs and outcomes. Activities are effective if they succeed in achieving the set goals. Meanwhile, efficiency focuses on optimizing the use of resources, which is achieving maximum output with minimal inputs. Activities are considered efficient if the ratio of output to input is high and compared to a specific performance standard.

METHOD

This study applies a qualitative research design with a systematic literature review approach to compare the health service systems of Kokumin Kenkou Hoken (KKH) in Japan and BPJS Kesehatan in Indonesia. The use of a literature-based method is grounded in the view of (Zed, 2014), who explains that literature studies constitute a research strategy that relies on the collection, evaluation, and interpretation of documented sources such as scholarly articles, books, official government publications, and international organizational reports. This approach is deemed appropriate because it enables an in-depth comparative analysis of both national health insurance systems without relying on direct field observation, while still ensuring access to comprehensive and validated data.

The research was conducted covering several sequential stages, beginning with literature mapping through academic databases including PubMed, JSTOR, Scopus, and Google Scholar. During this phase, relevant keywords were used to identify studies and official documents pertaining to health financing, policy governance, digital health integration, and service accessibility in both Japan and Indonesia. Following the mapping stage, a screening and source validation process was undertaken to ensure that only credible, recent, and contextually relevant materials were included in the analysis. Source criticism was performed to assess methodological rigor, reliability, and alignment with the research objectives.

In addition to secondary data, this study incorporates insights from selected expert informants who were consulted to enrich analytical interpretation. These informants consist of health policy academics, government officials involved in the administration of BPJS, and international health consultants familiar with global health financing models. They were selected purposively based on their expertise and relevance to the comparative health policy domain, providing contextual understanding that complements the literature findings.

The analysis process was carried out thematically by identifying, categorizing, and comparing key components of the two health service systems, including financing

structures, service coverage, accessibility patterns, and the integration of digital technologies. The comparative analysis aims to capture both convergence and divergence between the KKH and BPJS systems, thus offering a comprehensive understanding of how each country manages its national health insurance framework. Through this qualitative synthesis, the study produces insights that highlight structural strengths, systemic challenges, and strategic opportunities for policy improvement in developing countries such as Indonesia.

RESULTS AND DISCUSSION

Reliability of Health Service Quality in Japan's Kokumin Kenkou Hoken (KKH) and Indonesia's BPJS Kesehatan

The analysis of the reliability dimension serves to illuminate how consistently and accurately Japan's Kokumin Kenkou Hoken (KKH) and Indonesia's BPJS Kesehatan deliver health services that align with established clinical standards and patient expectations. Reliability is one of the most crucial elements of service quality, as it reflects a system's ability to provide stable, timely, and error-free services. Scholars have long emphasized the importance of reliability in shaping patient trust, system legitimacy, and long-term sustainability in healthcare delivery (Parasuraman et al., 1988). In this comparative context, the study examines the extent to which each national health insurance scheme can maintain dependable and standardized service performance across different regions and operational pressures. This investigation highlights operational stability, administrative accuracy, adherence to medical protocols, and continuity of financial and institutional support as core components that influence each country's reliability outcomes.

The theoretical foundation for this analysis is grounded in the TERRA framework, where reliability denotes the ability of a healthcare system to fulfill its service commitments, minimize errors, and sustain predictable performance even when service demands fluctuate. Reliability also depends on broader structural factors such as adequate financing, availability of medical personnel, efficiency of the referral process, and the capacity of healthcare facilities to uphold uniform standards across regions (Donabedian, 2003). These theoretical constructs allow for a structured and systematic comparison of KKH and BPJS Kesehatan, revealing how reliability emerges differently within distinct governance and resource environments.

Empirical interpretations of the reliability indicator show that Japan's KKH consistently achieves high performance across several dimensions. Previous research documents short waiting times, clear referral pathways, and equitable distribution of healthcare facilities across both urban and rural prefectures (Hashimoto, 2011). Japan also maintains strict national regulations on staffing ratios and continuous professional development, ensuring that healthcare workers are routinely trained and competent (Sato, 2021). The country's health insurance system, integrated since 1961, provides nearly universal and uninterrupted coverage, supported by a stable financing structure that includes national pooling and government subsidies. These features ensure timely claim reimbursements, minimize service disruptions, and enable hospitals to consistently maintain adequate supplies and operational capacity (Shibuya & Hashimoto, 2015). Collectively, these characteristics create a dependable and standardized health service environment, reinforcing public trust in the reliability of the KKH system.

In contrast, the reliability of Indonesia's BPJS Kesehatan remains inconsistent across regions due to several structural and operational limitations. Empirical studies reveal frequent delays in hospital claim reimbursements that disrupt operational

continuity and affect service quality (Tammase & al., 2020). High patient volumes contribute to long queues in hospitals and primary healthcare centers, reflecting a persistent mismatch between the number of BPJS participants and available facility capacity (Pratiwi & Laksono, 2022). Further, disparities in the distribution of healthcare personnel, particularly in 3T areas (frontier, outermost, and disadvantaged regions) result in inconsistent implementations of clinical protocols and varying levels of service performance (Mahendradhata, 2017). National audit reports reinforce these findings, showing pronounced provincial disparities in service reliability. Although BPJS has achieved significant progress in expanding coverage, it continues to face fundamental challenges that impede uniform and dependable service delivery.

The comparative analysis confirms that Japan's KKH demonstrates substantially higher reliability relative to Indonesia's BPJS Kesehatan. Japan's system benefits from long-standing financial stability, equitable resource allocation, uniform clinical standards, and consistent governance, enabling predictable and high-quality service performance nationwide. Conversely, BPJS Kesehatan's reliability is moderated by budget constraints, periodic deficits, unequal distribution of medical personnel, and heavy patient burdens in primary care, resulting in substantial variability in service quality and operational consistency. These findings underscore that reliable healthcare systems require not only adequate financing and human resources but also coherent governance and stable policy environments. Japan's decades of system continuity contrast with Indonesia's ongoing efforts to strengthen foundational infrastructure and administrative capacity, highlighting the structural reforms necessary to enhance the reliability of BPJS Kesehatan.

Table 1. Comparison of the Reliability Indicator Between Japan's KKH and Indonesia's BPJS Kesehatan

Aspect of Reliability	Kokumin Kenkou Hoken (KKH) – Japan	BPJS Kesehatan – Indonesia
Consistency of Service Delivery	Demonstrates high consistency due to long-standing system integration since 1961; services delivered uniformly across regions. (Shibuya & Hashimoto, 2015)	Service consistency remains variable; regional disparities persist, especially in rural and remote regions. (Mahendradhata et al., 2017a)
Timeliness (Waiting Time & Treatment Speed)	Short waiting times supported by clear referral pathways and adequate facility distribution. (Hashimoto et al., 2011)	Long queues and service delays common due to overcrowding and limited facility capacity. (Pratiwi & Laksono, 2022)
Accuracy of Service Delivery	High accuracy ensured by strict medical protocols, EMR usage, and well-regulated clinical standards.	Accuracy is inconsistent due to varying service quality, resource limitations, and workforce overload in primary care.
Stability of Financing and Claims	Stable financing with government covering ~50% of total health expenditures ensures timely reimbursement and uninterrupted operations.	Frequent delays in hospital claim reimbursements and periodic budget deficits affect operational reliability. (Tammase et al., 2020)
Availability and Distribution of Health Resources	Equitable distribution of healthcare professionals and facilities; national policies regulate staffing ratios. (Sato, 2021)	Uneven distribution of health workers, particularly in 3T regions, resulting in significant service gaps. (Mahendradhata et al., 2017a)
System Capacity to Handle High Service Demand	Reliable even under high demand due to strong infrastructure and digitized administrative systems (EMR, integrated health databases).	Capacity frequently overwhelmed, especially at primary healthcare centers (Puskesmas) with high patient loads.
Overall Reliability Assessment	Very high reliability supported by stable funding, technology integration, and strong governance.	Moderate to low reliability; system faces structural constraints in financing, workforce distribution, and facility capacity.

Responsiveness of Health Service Quality in Japan's KKH and Indonesia's BPJS Kesehatan

The analysis of the responsiveness dimension in this comparative study is intended to explain how effectively Japan's Kokumin Kenkou Hoken (KKH) and Indonesia's BPJS Kesehatan address patient needs through timely, accurate, and proactive service delivery. Responsiveness offers an important perspective for examining how health systems function under diverse demographic pressures, administrative arrangements, and resource conditions. Within this context, the study seeks to answer a central research

question: How quickly and appropriately do Japan and Indonesia respond to patient needs across different levels of care? Understanding these dynamics is essential because responsiveness directly influences system efficiency, patient perceptions, and the broader quality of public health services (V. A. Zeithaml et al., 2012). By focusing on this dimension, the study illustrates the operational realities and service performance of two distinct national health insurance models.

Conceptually, the analysis utilizes the responsiveness construct within the TERRA framework, which emphasizes a provider's willingness and capacity to deliver prompt, accurate, and delay-free services. In healthcare settings, responsiveness is seen in rapid administrative processes, timely access to medical professionals, accurate information sharing, and the ability of health organizations to coordinate in real time across departments and facilities. These elements are consistent with established theories of healthcare quality, particularly (Donabedian, 2003) assertion that timely and coordinated service delivery is fundamental to patient satisfaction and improved clinical outcomes. Through this theoretical lens, the study evaluates how the structural and technological differences between KKH and BPJS shape their service responsiveness.

Field-based evidence from Japan consistently demonstrates that KKH exhibits a high level of responsiveness supported by mature digital systems, efficient administrative processes, and an evenly distributed healthcare workforce. Digital appointment systems significantly reduce waiting times and allow patients to manage visits efficiently. Telemedicine platforms, widely adopted across regions, support elderly citizens and residents of rural areas by facilitating remote consultations and reducing travel burdens (M. Fujita et al., 2020). Japan's real-time clinical data integration further enables swift referrals between facilities, ensuring continuity of care and faster decision-making (Sato, 2021). Moreover, Japan's flexible provider-choice model allows patients to directly access various types of care without excessive bureaucratic filtering, enhancing the system's overall responsiveness. Continuous investment in staff training further reinforces consistent quality and speed of patient interactions.

In contrast, responsiveness in Indonesia's BPJS Kesehatan system shows considerable variation across service levels and regions. High patient volumes, particularly in puskesmas and lower-class hospitals regularly result in congestion, prolonged administrative procedures, and long waiting times (Pratiwi & Laksono, 2022). Limited human resources in 3T (frontier, outermost, disadvantaged) areas also constrain the system's ability to respond promptly to urgent medical needs (Mahendradhata et al., 2017a). While Indonesia has introduced digital systems such as Mobile JKN and VClaim to streamline services, implementation remains inconsistent, with many facilities experiencing referral delays, technical problems, and insufficient digital support (Tammase & al., 2020). Bureaucratic referral rules add further delays, particularly for patients seeking specialized care, highlighting systemic obstacles to timely service delivery.

The comparative analysis reveals a clear and consistent gap between the two systems. Japan's KKH achieves high responsiveness due to strong technological integration, simplified administrative processes, and balanced workforce distribution. These conditions create an environment where patients receive timely information, prompt consultations, and efficient referrals. Conversely, BPJS Kesehatan faces structural limitations such as overcrowded facilities, shortages of medical personnel, immature digital infrastructure, and complex referral procedures, all of which hinder timely service delivery. These challenges are especially visible in long waiting times and inconsistent administrative responsiveness across primary care settings.

In conclusion, the findings emphasize that health system responsiveness is deeply shaped by technological readiness, equitable distribution of healthcare workers, and streamlined governance structures. Japan's sustained investment in digitalization and institutional reforms has resulted in a highly responsive system, while Indonesia continues to build foundational capacities to reduce delays and improve the patient experience under BPJS Kesehatan. Strengthening digital interoperability, increasing workforce distribution equity, and simplifying referral regulations emerge as essential steps for improving responsiveness in Indonesia's national health insurance framework.

Table 2. Comparison Responsiveness Indicator (TERRA Framework)

Indicator of Responsiveness	Japan – Kokumin Kenkou Hoken (KKH)	Indonesia – BPJS Kesehatan
Speed of Administrative Procedures	Highly efficient through digital appointment systems; waiting times significantly reduced due to automated scheduling and streamlined check-in processes.	Often slow due to manual or partially digital systems; long queues occur at puskesmas and hospitals because of high patient volume.
Timeliness of Medical Consultations	Telemedicine and real-time clinical data support rapid consultations; direct access to facilities without complex referrals increases service speed.	Limited by crowded facilities, shortage of healthcare workers, and multi-layered referral system that delays specialist access.
Readiness of Health Personnel	Staff receive continuous professional training focusing on rapid response, patient-centered communication, and immediate clinical support.	Readiness varies; many providers face fatigue and overload. Staffing shortages in rural/3T areas reduce response capability.
Accuracy of Information Provided to Patients	Supported by integrated digital health records and real-time information systems; reduces administrative errors and miscommunication.	Information accuracy is inconsistent; digital tools like Mobile JKN exist but adoption is uneven and system disruptions remain common.
Availability of Support Services	Wide availability of support services, including remote consultations, automated reminders, and digital follow-up systems.	Limited support services; telemedicine use is still emerging, and follow-up systems lack standardization across regions.
Referral System Efficiency	No layered referral requirement; patients may directly choose healthcare providers, increasing overall responsiveness.	Multi-level referral pathways slow down patient mobility and increase waiting time for specialist care.
Overall Responsiveness Performance	High—supported by strong digitalization, reliable workforce, and efficient administrative pathways.	Moderate to low—affected by infrastructure gaps, high workload, and inconsistent digital readiness.

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Assurance of Health Service Quality in Japan's KKH and Indonesia's BPJS Kesehatan

The analysis of the assurance dimension in this comparative study seeks to understand how effectively Japan's Kokumin Kenkou Hoken (KKH) and Indonesia's BPJS Kesehatan provide certainty, safety, and professional reliability within their healthcare systems. Assurance is a fundamental component of public trust because it represents the extent to which health services can guarantee secure, predictable, and competent care. Within this context, the research focuses on answering how far KKH and BPJS Kesehatan are able to deliver reliable service certainty and maintain professional competence across various healthcare settings. In the broader discourse of health policy, assurance has long been associated with patient confidence, perceived safety, and institutional credibility, making it a critical determinant of the public's trust in universal healthcare systems (Donabedian, 2003).

The conceptual grounding of this study adopts the TERRA framework, in which assurance encompasses professional competence, adherence to national safety standards, transparency of administrative processes, clarity in financial coverage, and the ability of institutions to maintain patient trust. Scholars emphasize that stronger assurance mechanisms consistently correlate with higher patient satisfaction and greater system legitimacy (Anderson et al., 2019). Through this lens, the comparative analysis between Japan and Indonesia allows the identification of structural, procedural, and governance differences that influence the reliability of their respective healthcare systems.

Field findings demonstrate that Japan's KKH system delivers remarkably high assurance due to long-standing regulatory stability, institutional consistency, and advanced administrative transparency. Professional competence is upheld through rigorous national medical examinations, strict licensure renewal mechanisms, and continuous professional development, ensuring that medical practitioners across all prefectures maintain standardized levels of expertise (Sato, 2021). The existence of a nationally standardized fee schedule further strengthens the assurance dimension by providing absolute price predictability for all medical procedures, eliminating regional disparities and preventing financial uncertainty among citizens (Shibuya & Hashimoto, 2015). This financial clarity is reinforced by a digitalized administrative environment in which electronic medical records and integrated hospital information systems enable accurate dissemination of information regarding treatment processes, insurance coverage, and expected service timelines (S. Fujita, 2020). Moreover, legal frameworks such as the Medical Care Act require facilities to publish performance indicators, thereby promoting transparency and institutional accountability. Together, these features position KKH as a system with exceptionally strong assurance performance, reflected in consistently high levels of public trust and perceived fairness.

In contrast, Indonesia's BPJS Kesehatan demonstrates a more uneven assurance profile. While the program has significantly expanded financial protection and improved access through the Jaminan Kesehatan Nasional (JKN), assurance outcomes remain variable due to disparities in healthcare workforce competence, administrative inconsistencies, and communication gaps. Although BPJS provides substantial coverage for essential medical services, unclear communication regarding non-covered treatments and unexpected additional costs continues to weaken patient confidence (Mahendradhata et al., 2017a). The uneven distribution of medical professionals across Indonesia's regions contributes to inconsistent service quality, particularly in remote or underserved areas where limited specialist availability and fewer training opportunities persist (Pratiwi & Laksono, 2022). Procedural transparency also remains a challenge, as many BPJS-affiliated

facilities provide incomplete information about referral mechanisms, waiting times, and administrative requirements, an issue that frequently leads to patient confusion and dissatisfaction (Tammase & al., 2020). Furthermore, bureaucratic complexities in the tiered referral system often generate uncertainty and procedural delays, reducing the system's ability to deliver dependable and predictable healthcare experiences.

The comparative assessment reveals a marked contrast in assurance performance between the two systems. Japan's KKH exhibits consistently high assurance through predictable administrative processes, transparent financial mechanisms, and robust professional standardization supported by clear legal frameworks. These features collectively create a stable and trustworthy environment in which patients experience dependable, equitable, and professionally competent care. Meanwhile, BPJS Kesehatan demonstrates moderate assurance performance. Although it provides strong financial protection at the policy level, its service delivery is hindered by uneven provider competence, inconsistent communication practices, and administrative barriers that undermine patient confidence.

The observed assurance gap reflects differences in institutional maturity, regulatory enforcement, and the extent to which professional and administrative standards are applied uniformly. For Indonesia to strengthen the assurance dimension of BPJS Kesehatan, several key areas require prioritization, including competency-based workforce development, national standardization of service communication, stronger enforcement of financial transparency, and simplification of referral procedures. By addressing these structural and operational gaps, Indonesia can enhance public trust and move toward a more resilient and predictable healthcare system comparable to Japan's KKH benchmark.

Table 3. Comparison Assurance of Health Service Quality in Japan's KKH and Indonesia's BPJS Kesehatan

Assurance Indicator	Japan – Kokumin Kenkou Hoken (KKH)	Indonesia – BPJS Kesehatan
Professional Competence of Healthcare Workers	In Japan, healthcare personnel are required to pass rigorous national examinations, undergo periodic re-certification, and participate in continuous professional development. These strict regulatory mechanisms produce a consistently high level of professional competence across all regions.	In Indonesia, the competence of healthcare workers varies significantly between regions. Disparities arise due to uneven distribution of specialists and limited access to structured training programs, particularly in remote and underserved areas.
Clinical Safety and Security Assurance	The Japanese system benefits from strong adherence to national clinical guidelines supported by comprehensive legal frameworks such as the Medical Care Act. Healthcare facilities are obligated to publish performance indicators, reinforcing patient safety, clinical accountability, and system-wide transparency.	The implementation of clinical safety standards in Indonesia shows substantial variation. Some facilities apply national guidelines effectively, while others struggle with inconsistent enforcement and limited oversight, resulting in uneven levels of patient safety.

Assurance Indicator	Japan – Kokumin Kenkou Hoken (KKH)	Indonesia – BPJS Kesehatan
Clarity and Transparency of Service Procedures	Hospitals in Japan consistently provide clear explanations of procedures, insurance coverage, referral pathways, and expected treatment timelines. This high degree of transparency enhances patient confidence and facilitates predictable service experiences.	In Indonesia, transparency remains inconsistent. Many BPJS-affiliated facilities provide incomplete information regarding referral requirements, service eligibility, waiting times, and potential out-of-pocket expenses, which contributes to patient uncertainty.
Financial Certainty and Cost Predictability	Japan's nationwide fee schedule regulates the cost of all medical services, ensuring uniform tariffs regardless of location or type of facility. This creates strong financial predictability and eliminates ambiguity regarding patient expenses.	BPJS Kesehatan offers broad financial protection, but communication about cost coverage is frequently unclear. Patients often encounter unexpected fees or insufficient explanations about non-covered services, reducing financial certainty.
Trust-Building Mechanisms	Assurance in the KKH system is reinforced by long-standing institutional stability, clear legal protections, standardized procedures, and consistently high-quality professional services. These factors collectively foster high public trust in the healthcare system.	In the BPJS system, public trust is moderate. While financial protection is significant, trust is weakened by inconsistencies in service quality, bureaucratic complexity, and variations in provider communication practices across regions.
Administrative Reliability	Administrative processes under KKH are highly uniform across regions, enabling predictable service delivery and minimizing administrative burdens for patients.	Administrative procedures in BPJS Kesehatan are often perceived as cumbersome, particularly due to the tiered referral system. This complexity contributes to service delays and creates uncertainty for patients seeking specialist care.
Overall Assurance Performance	The KKH system demonstrates a high level of assurance characterized by predictable clinical pathways, transparent procedures, standardized competency requirements, and strong patient protection frameworks.	BPJS Kesehatan exhibits moderate assurance. Although financial protection is robust, inconsistent information, variability in clinical competence, and procedural complexity limit the overall level of certainty experienced by patients.

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Empathy in Health Service Quality: A Comparative Analysis between Japan's KKH and Indonesia's BPJS Kesehatan

The analysis of empathy in this study seeks to understand how healthcare personnel within Japan's Kokumin Kenkou Hoken (KKH) system and Indonesia's BPJS Kesehatan demonstrate personal attention, courtesy, and meaningful interpersonal communication throughout the service process. Empathy is not merely an interpersonal attribute; it is a foundational component of patient-centered care and one of the strongest determinants of patient satisfaction, trust in healthcare institutions, and adherence to medical guidance. In this context, the analysis responds directly to the central research question concerning the extent to which healthcare workers in both systems show genuine personal attention and sensitivity toward patient needs during service encounters. The broader health policy literature reinforces the importance of this dimension, consistently linking empathetic care with improved treatment adherence, enhanced perceptions of system reliability, and higher levels of patient satisfaction overall (Derksen et al., 2013; Mercer & Reynolds, 2002). Understanding how empathy is expressed in the daily operations of these two national health insurance systems therefore provides important insight into the humanistic and relational foundations of healthcare quality that shape patient experiences and outcomes.

Within the TERRA service quality framework, empathy reflects a system's capacity to provide care that is attentive, respectful, and responsive to the unique concerns of each individual patient. This dimension is anchored in active listening, personalized attention, and sincere efforts by providers to understand patient perspectives. It also encompasses the courtesy expressed by both clinical and administrative staff, the clarity and warmth embedded in interpersonal communication, and the emotional sensitivity required when interacting with vulnerable populations such as older adults, children, or individuals facing chronic or life-limiting illnesses. Scholars have repeatedly noted that empathy functions as both a predictor of trust and a mechanism for sustaining therapeutic relationships over time, making it a fundamental element in the evaluation of service quality in healthcare systems (Beach & al., 2006; Hojat, 2016).

Empirical findings reveal that empathy within Japan's KKH is generally strong, influenced by cultural norms and supported by robust institutional expectations regarding respectful and patient-centered communication. Interactions between patients and healthcare professionals in Japan are deeply shaped by cultural values such as teinei—politeness—and omotenashi, or wholehearted hospitality. These values manifest in the form of attentive listening, calm and courteous explanations, and a consistent sensitivity to patient concerns, all of which reinforce the perception that patients are respected and genuinely cared for (Nagata & al., 2019a). This cultural foundation is strengthened by professional training, as interpersonal communication, shared decision-making, and empathy are woven into medical and nursing education. Studies show that Japanese healthcare workers receive structured preparation aimed at enhancing communication competencies, enabling them to manage patient encounters with emotional awareness and sincerity (Ishikawa et al., 2013).

Another contributing factor to the expression of empathy in the KKH system is the manageable patient load in many outpatient facilities, particularly in suburban and rural areas. While certain urban hospitals experience high demand, many healthcare settings maintain balanced patient-to-provider ratios that allow clinicians adequate time for consultation, explanation, and personalized interaction. As a result, patient surveys in Japan consistently report high levels of perceived empathy, with patients describing providers who listen carefully, explain treatment options clearly, and respond thoughtfully

to individual concerns (M. Fujita et al., 2020). These practices enhance system trustworthiness and reinforce the legitimacy of the national insurance program.

In contrast, empathy within Indonesia's BPJS Kesehatan system varies considerably and remains a key challenge, particularly at the Primary Health Care (FKTP) level where service demand is greatest. Overcrowding is a central barrier, as many public puskesmas and hospital outpatient clinics experience heavy patient volumes that significantly limit consultation time. Under these conditions, opportunities for personal engagement, detailed explanation, and attentive listening are often constrained. Research indicates that these structural pressures not only hinder empathetic interactions but also shape patient perceptions that healthcare workers are disengaged or inattentive, even when the root cause is insufficient staffing or time rather than a lack of willingness to help (Putri et al., 2020).

Communication issues further complicate empathy delivery. Patients frequently report rushed interactions with limited explanation of diagnoses or treatment procedures, contributing to feelings of uncertainty and dissatisfaction (Tammase et al., 2020). Regional disparities exacerbate these problems, as urban facilities tend to offer stronger communication practices due to better staffing and greater access to training. Meanwhile, many rural and remote regions struggle with personnel shortages and high workloads, resulting in inconsistent expressions of empathy across the country (Pratiwi & Laksono, 2022). The cultural and institutional environment also plays a role. Unlike Japan, where norms of courtesy and structured communication have been embedded in healthcare practice for decades, Indonesia is still in the process of institutionalizing patient-centered communication within its healthcare system. While reforms and training programs aimed at improving empathy are underway, implementation remains uneven and varies by facility (Mahendradhata et al., 2017a).

The overall comparison of these two systems reveals pronounced differences in the expression of empathy. Japan's KKH benefits from longstanding cultural traditions, structured communication training, balanced workloads in many facilities, and institutional frameworks that support respectful and emotionally sensitive interactions. These conditions collectively produce a healthcare experience in which patients commonly feel understood, valued, and personally attended to. In contrast, BPJS Kesehatan exhibits moderate to low levels of perceived empathy, constrained primarily by systemic factors such as overcrowded facilities, uneven distribution of healthcare personnel, and inconsistent communication practices. The resulting limitations often prevent healthcare workers from dedicating sufficient time to patients, producing a service environment where interactions may feel rushed, impersonal, or insufficiently explained.

Empathy therefore emerges as a clear differentiating factor between Japan's well-established and culturally aligned KKH system and Indonesia's rapidly expanding but structurally strained BPJS Kesehatan. For Indonesia to strengthen this dimension of service quality, efforts must continue to focus on expanding human resources, improving communication training, and reducing facility overcrowding so that healthcare providers have the capacity to offer more meaningful attention to patients.

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Table 4. Empathy in Health Service Quality

Aspect of Empathy	Japan – Kokumin Kenkou Hoken (KKH)	Indonesia – BPJS Kesehatan
Personal Attention to Patients	Health services under KKH demonstrate consistent and standardized personal attention. Healthcare providers allocate sufficient time for each patient and ensure that every concern is thoroughly understood. This practice is closely linked to the Japanese *omotenashi* culture, which emphasizes sincerity, attentiveness, and genuine care in service delivery.	In many BPJS-affiliated facilities, personal attention is often constrained by high patient volumes and limited medical staff. Consultation time is generally short, resulting in suboptimal personal attention, particularly at primary healthcare centers where workload is heavy.
Courtesy and Respect	Japan's health system is grounded in strong values of courtesy and respect toward individuals. Healthcare workers tend to communicate politely, create a sense of comfort, and demonstrate empathy throughout patient interactions.	Although many healthcare workers display politeness, the level of courtesy varies significantly across regions. Complaints about hurried interactions or insufficient friendliness still arise, especially in facilities struggling with heavy service burdens.
Communication Quality	Communication in Japanese healthcare facilities is typically clear, careful, and oriented toward patient understanding. Medical explanations are delivered in a structured way, allowing patients to feel heard and well-informed about their condition.	Communication in BPJS facilities is often affected by limited consultation time. Patients frequently report that medical explanations are not sufficiently detailed, causing the empathetic communication dimension to be inconsistently achieved.
Emotional Support	Healthcare providers in Japan offer emotional support by paying attention to patients' psychological comfort. The overall service approach fosters a sense of safety, reassurance, and trust between patients and providers.	Emotional support varies widely, and tends to diminish in overcrowded service environments. Due to high workloads, healthcare workers often prioritize administrative and clinical tasks, leaving less room for emotional engagement with patients.
Influencing Factors	Work culture in Japan—characterized by discipline, interpersonal respect, and standardized service procedures—ensures that the empathy dimension is consistently implemented across the system.	Key challenges include heavy workloads, uneven distribution of healthcare personnel, and variation in service standards across regions. These conditions limit the ability of healthcare workers to consistently deliver empathetic services.

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Tangibles in Health Service Quality: A Comparative Analysis between Japan's KKH and Indonesia's BPJS Kesehatan

The analysis of the tangibles dimension in this study is aimed at understanding how physical facilities, medical equipment, and technological infrastructure shape public perceptions of healthcare quality within Japan's Kokumin Kenkou Hoken (KKH) and Indonesia's BPJS Kesehatan. Tangible elements represent the most visible aspects of service delivery, often becoming the first indicators patients use to judge reliability, safety, and professionalism. Cleanliness, comfort, facility organization, and the presence of modern medical technology significantly influence patient trust and shape their expectations of healthcare institutions. As highlighted in service quality theory, tangibles are closely linked to perceived competence and institutional credibility, making them essential for analyzing system readiness and equity in both countries (Dagger et al., 2007; Parasuraman et al., 1988). The central question guiding this analysis concerns how the physical environment, adequacy of medical tools, and adoption of technological innovations contribute to the perceived quality of healthcare under different national insurance systems.

In the TERRA or broader Service Quality models, tangible dimensions serve as critical indicators of service performance. They embody the physical aspects of care, including the hygiene and maintenance of facilities, the comfort of waiting and examination areas, the completeness and modernity of available diagnostic equipment, the utilization of digital technologies such as electronic medical records (EMR) and telemedicine, and the overall visual professionalism displayed throughout the healthcare setting. Scholars argue that superior physical environments not only support better clinical outcomes but also generate a strong psychological sense of safety and trust among patients, especially in high-contact service sectors like healthcare (Aljaberi et al., 2022; Roh et al., 2021). These theoretical foundations provide the basis for evaluating the role of tangibles in distinguishing the quality of health services between advanced and developing healthcare systems.

Field observations and empirical literature show that Japan's KKH system consistently demonstrates exceptional performance in the tangibles dimension. Japanese healthcare facilities, whether hospitals or clinics, public or private typically adhere to strict national standards governing cleanliness, structural safety, and facility maintenance. Regulations issued by the Ministry of Health, Labour and Welfare ensure uniformity in facility inspection procedures and quality benchmarks. Research indicates that Japanese patients place considerable value on the orderly, clean, and well-maintained physical environment of healthcare institutions, which contributes significantly to their overall satisfaction (Nagata & al., 2019b). Technological integration also plays a notable role in shaping Japan's healthcare tangibles. More than 90 percent of hospitals and clinics use electronic medical records and digital hospital information systems, facilitating seamless administrative workflows, shorter waiting times, and more accurate diagnostics (Kashihara et al., 2019). Japan also maintains one of the highest densities of medical imaging and diagnostic equipment globally, ensuring timely and precise medical examinations (Mori et al., 2017). Crucially, the consistency in infrastructure quality across urban and rural regions reinforces Japan's reputation for equitable and patient-centered healthcare delivery. The combination of modern facilities, advanced digital systems, and strict adherence to quality standards creates a healthcare environment that is technologically mature, clean, and reassuring for patients.

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In contrast, the tangible conditions of healthcare facilities within Indonesia's BPJS Kesehatan system demonstrate substantial variability. Urban hospitals, particularly type A and B institutions, tend to have adequate buildings, cleaner environments, and better-equipped diagnostics. However, primary care centers (puskesmas) in rural, remote, or economically constrained areas frequently struggle with infrastructure limitations. Many of these facilities operate within outdated buildings, have limited maintenance budgets, and suffer from a shortage of basic diagnostic equipment such as laboratory tools, X-ray devices, and sterilization units (Pratiwi & Laksono, 2022). Technological integration also remains inconsistent. While BPJS has introduced systems such as P-Care and SATUSEHAT, many health facilities continue to rely on manual registration processes and paper-based medical records, limiting efficiency and weakening patient perceptions of service professionalism (Mahendradhata et al., 2017b). High patient volumes in densely populated areas further exacerbate tangible challenges, leading to overcrowded waiting rooms, extended queues, and cleanliness issues that diminish service quality (Putrihapsari & Fauziah, 2020). These conditions reflect broader structural disparities related to regional economic capacity, uneven distribution of healthcare resources, and limited infrastructural investment.

The comparison between Japan and Indonesia reveals a significant contrast in the tangibles dimension. Japan's superior performance can be attributed to long-term investment in advanced technologies, nationwide digitalization, consistent facility maintenance, and well-enforced national standards. These elements not only enhance operational efficiency but also create a cohesive patient experience characterized by cleanliness, orderliness, and technological sophistication. Meanwhile, Indonesia's varied outcomes in the tangibles dimension demonstrate the challenges of managing a large, geographically diverse healthcare system under resource constraints. Disparities in regional budgets, uneven facility readiness, and limited technological adoption result in strong quality variations between urban and rural healthcare facilities. Consequently, patient perceptions of BPJS service quality are heavily influenced by geographical context and infrastructure availability.

In conclusion, the tangibles dimension underscores a fundamental structural gap between Japan's KKH and Indonesia's BPJS Kesehatan. Japan's health system benefits from its mature infrastructure and uniform technological integration, allowing it to deliver consistently high-quality physical environments across regions. Indonesia, although progressing steadily, continues to face tangible limitations driven by regional inequalities, technological gaps, and insufficient facility investment. Addressing these disparities, through expanded digitalization, infrastructure enhancement, and equitable resource distribution is essential for strengthening healthcare quality and improving patient satisfaction within the BPJS system.

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Table 5. Comparison Tangibles Indicator (Japan's Kokumin Kenkou Hoken vs Indonesia's BPJS Kesehatan)

Aspect	Kokumin Kenkou Hoken (Japan)	BPJS Kesehatan (Indonesia)
Quality and Modernity of Facilities	Health facilities under KKH generally display a consistently modern infrastructure supported by long-term national investment. Hospitals are equipped with advanced medical equipment, well-maintained buildings, and standardized room layouts that create a sense of professionalism and comfort for patients.	Facilities under BPJS vary significantly across regions. Urban hospitals tend to be well-equipped with relatively modern infrastructure, but many rural facilities still struggle with limited resources, outdated equipment, and buildings that require renovation, which affects the perceived quality of service.
Cleanliness and Physical Environment	Japanese hospitals operate under strict sanitation protocols that ensure high cleanliness standards. Waiting areas, examination rooms, and medical equipment are maintained with meticulous attention, contributing to patient trust and comfort.	Cleanliness levels in BPJS-affiliated facilities differ widely. Larger hospitals often maintain good hygiene, but smaller clinics and remote puskesmas sometimes face challenges such as limited cleaning staff, insufficient sanitation tools, and overcrowded spaces that hinder consistent cleanliness.
Availability of Medical Equipment	Medical tools and diagnostic devices in KKH facilities are generally up-to-date, regularly calibrated, and available in sufficient quantity. This ensures smooth service delivery without delays due to equipment shortages.	BPJS facilities experience unequal distribution of equipment; major hospitals may have advanced tools, while many primary care centers report shortages in diagnostic devices, laboratory equipment, and essential medical instruments, leading to longer waiting times and potential treatment delays.
Use of Health Information Technology (EMR/SIMRS)	More than 90% of hospitals in Japan have integrated electronic medical records and hospital information systems. These systems function seamlessly to support clinical decisions, reduce administrative errors, and speed up patient services.	Implementation of SIMRS and EMR in Indonesia is progressing but remains inconsistent. Some hospitals use digital systems effectively, whereas many others—particularly in less developed regions—still rely on manual records, resulting in slower service and increased administrative burden.

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Overall Patient Perception of Tangibles	Patients generally perceive Japanese facilities as highly reliable because of their physical comfort, technological sophistication, and cleanliness, which reinforce confidence in the system.	Public perception of Indonesia's BPJS tangibles tends to mirror the disparities in facility conditions. Positive perceptions emerge in well-developed areas, while dissatisfaction is more common in regions with poor infrastructure and limited medical resources.

CONCLUSION

This study analyzes differences in the quality, efficiency, and accessibility of health services in Japan's Kokumin Kenkou Hoken (KKH) and Indonesia's BPJS Kesehatan by examining how system design, technological infrastructure, and financing mechanisms shape service outcomes. The findings based on the research objectives show that KKH consistently provides high-quality and equitable services through strong government subsidies, standardized facility management, and extensive use of Electronic Medical Records (EMR) and telemedicine. These factors contribute to superior health indicators, including higher life expectancy and lower infant mortality. In contrast, BPJS demonstrates structural constraints, particularly inconsistent facility readiness, financing deficits, and variations in service quality which limit its ability to deliver uniform and efficient care.

In answering the research questions, the study reveals that technological integration (EMR, telemedicine, digital claims systems), financing stability, and facility standardization are the critical determinants of performance differences between the two systems. While BPJS has adopted digital innovations such as Mobile JKN and VClaim, their effectiveness remains hindered by infrastructure disparities, long waiting times, unequal access in remote areas, and low compliance in premium contributions.

Based on these findings, this research recommends that Indonesia strengthen BPJS by adapting proven strategies from KKH, including large-scale EMR adoption, expansion of telemedicine, standardized facility investment, and big-data-based service management. Enhancing digital literacy among citizens and health workers, along with developing sustainable financing models and transparent fund governance, is also essential to improve service equity and efficiency.

This study is limited by its reliance on secondary data and cross-country comparative design, which may not fully capture variations across regions and facility types within each country. Future research should incorporate primary field data, longitudinal assessments, and deeper analysis of patient experiences to build a more comprehensive understanding of health system performance.

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