# When Trust Matters More Than Service: Reframing Brand Image Benefits in a BPJS-Dominated Private Hospital

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## Abstract

Strategic brand management differentiates brand image benefits into functional, experiential, and symbolic dimensions, yet how these benefits are prioritized within universal healthcare settings remains underexplored. This qualitative study examines a private hospital in Jember, Indonesia, that has served an unusually high proportion of BPJS patients—approximately 80% over the past five years—despite regulations requiring private hospitals to allocate a minimum of 40% of their services beneficiaries under BPJS Kesehatan, administered by BPJS Kesehatan under Indonesia's national health insurance system (JKN). Such high dependence may constrain their brand positioning. The study asks which dimension of brand benefit is strategically prioritized by institutional actors operating under high UHC dependence. Data were collected through in-depth interviews with five internal stakeholders including director, manager, and media members responsible for strategic communication, analyzed using thematic analysis. The focus on internal actors reflects their institutional knowledge and their role in shaping brand positioning based on accumulated patient feedback. Participants described functional benefits (effective treatment, procedural clarity), experiential benefits (comfort, simplicity), and symbolic benefits (trust, security, and religious alignment). While functional and experiential benefits were largely treated as expected standards under UHC, symbolic benefits emerged as more influential in shaping institutional identity and public legitimacy. The study suggests that when private hospitals exceed BPJS participation requirements, symbolic meaning becomes central to maintaining credibility. The novelty of this research lies in conceptualizing symbolic brand benefits as a strategic form of institutional decision-making that sustains private healthcare organizations operating under UHC regimes in Indonesia and comparable Asian contexts.

*Keywords:* brand image benefits, universal health coverage, private hospital, strategic brand management, thematic analysis

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## Introduction

Universal health coverage (UHC) is built on a simple, demanding promise: that all people should be able to obtain the health services they need, when and where they need them, without financial hardship. The World Health Organization (WHO, 2025) defines UHC in precisely these terms and treats it as a core health-systems goal rather than a single policy instrument. In practice, countries pursue UHC through different institutional pathways. Some rely primarily on tax-funded national health services, others on social health insurance, and others on mixed arrangements that combine public financing, mandatory contributions, and targeted subsidies. UHC, then, is not a uniform formula. It is a social commitment translated through different financing systems, institutional logics, and public meanings (WHO, 2025). Once UHC becomes part of everyday life, it shape how healthcare organizations are perceived. In strategic brand management, brand image refers to the associations people attach to a brand, which are commonly understood through three benefit dimensions: functional, experiential, and symbolic (Keller & Swaminathan, 2019). Functional benefit relates to concrete utility, such as facilities, medical capability, or perceived service quality. Experiential benefit concerns how the service feels in use, including ease, comfort, emotional tone, and process clarity. Symbolic benefit relates to deeper meanings, such as trust, dignity, belonging, care, or social identity. These associations matter because they shape how people interpret a brand long before they conduct a formal comparison. They are also socially transmissible: they circulate through stories, recommendations, complaints, and recurring public impressions, whether those impressions are fully objective, partially subjective, or a mixture of both.

Indonesia implements UHC through *Jaminan Kesehatan Nasional* (JKN), administered by BPJS Kesehatan. Since its rollout in 2014, JKN expanded at an exceptional pace, reaching roughly 97–98% of the population within just over a decade. This makes Indonesia one of the fastest large-scale UHC expansions in the world. The system is designed for broad inclusion: formal workers are commonly enrolled through their employers, subsidized groups are covered by the state, and independent members can register through BPJS channels such as Mobile JKN using their population identity data and a selected primary care facility. Indonesian Ministry of Health explicitly reminded hospitals not to discriminate against their patients in the provision of services, and requires public hospitals to allocate at least 60% of their patient beds for BPJS patients and private hospitals to allocate at least 40%.

However, the success of a health system does not automatically remove public tension around it. In Indonesia, JKN has generated both positive and negative perceptions across research and public discussion. Public sentiment toward BPJS Kesehatan has been widely discussed in both academic studies and digital platforms. A Twitter-based study found that BPJS-related tweets in May 2020 were almost evenly divided between positive sentiment (52%) and negative sentiment (48%), showing that public evaluation of BPJS is highly dynamic (Yunus et al., 2021). Puspita and Widodo argue that BPJS has become a widely used healthcare scheme that also invites ongoing debate in online discourse, reflecting both perceived benefits and dissatisfaction among users. Research on Instagram comments likewise shows that public feedback toward BPJS services includes both supportive and critical responses, indicating that social media has become an important space where citizens evaluate healthcare services and express their experiences publicly. This tension becomes even more visible when BPJS is discussed in relation to policy change. Public responses to changes in BPJS contribution policy were strongly marked by negative sentiment, and they argue that such findings should encourage improvements in service quality and institutional

communication (Damayanti et al., 2024). At the same time, from the medical and provider's side, workers describe a heavier burden falls on them: high patient volume, staff cannot always keep the pace, and frontline personnel often end up spending considerable time explaining procedures, referrals, and benefit entitlements beyond their core clinical responsibilities.

The key issue is not whether every public complaint or defense of BPJS is objectively correct. The evidence is not entirely one-directional. Some studies report no meaningful discrimination and show that patient perceptions vary across institutions and service contexts (Karim et al., 2022). Those perceptions can shape how patients approach hospitals before they even receive UHC care. In other words, hospitals operating in a BPJS-dominant environment do not manage services alone; they also manage accumulated public meaning. This is why brand image becomes strategically important in the context of healthcare (Cham et al., 2020). This study addresses that gap through an extreme private-hospital case in Jember, East Java, Indonesia. The selected hospital has been dominated by BPJS patients for years and reportedly serves roughly twice the minimum standard-class inpatient bed proportion mandated for private hospitals. In a context where some private hospitals seek to limit their exposure to BPJS-heavy demand, this case is strategically significant. Rather than asking patients which attributes they prefer, this study asks the people shaping the hospital's institutional voice how they understand the brand's strength. The research question is therefore: which dimension of brand image benefit is strategically prioritized by internal institutional actors in a private hospital operating under high UHC dependence?

## Methodology

This study used an attitudinal qualitative design because the phenomenon under examination is perceptual, interpretive, and strategically constructed. Following Rohrer's (2022) classification of user research approaches, attitudinal qualitative inquiry is appropriate when the goal is to understand meanings, values, and decision logics rather than merely count observable behaviour. The study also adopted a single-case study approach because the selected hospital represented an information-rich and strategically significant case for examining branding under UHC pressure. The inquiry was framed through the Discover and Define phases of the Double Diamond model developed by the Design Council (2019). The Discover phase was used to gather broad insight from multiple organizational touchpoints and from public-facing digital feedback, and the Define phase was used to synthesize those inputs into a sharper understanding of the hospital's dominant brand image benefit (Lewrick et al., 2025). The analytical lens for classifying brand meaning was drawn from strategic brand management, specifically the distinction between functional, experiential, and symbolic brand image benefits (Keller & Swaminathan, 2019).

Primary data were collected through in-depth, face-to-face interviews with five internal stakeholders who had direct relevance to institutional decision-making, public communication, patient interaction, or service delivery. To protect confidentiality, the interviewees are identified as ST1 to ST5. Each interview lasted at least 30 minutes and followed the same semi-structured protocol, allowing the researcher to probe how stakeholders interpreted patient choice, hospital distinctiveness, and the role of BPJS-related realities in shaping the brand. Stakeholder selection was aligned through stakeholder theory, particularly by mapping actors by power and influence (Freeman, 1984). Stakeholder mapping was determined from informants' relative power and level of involvement in shaping the hospital's brand and practices, rather than from formal job title alone. This was

necessary because the hospital did not yet have a dedicated branding unit or a rigid communication workflow. This mapping clarified that the hospital's brand was being shaped through distributed practice rather than a single formal branding unit.

**Table 1**
*Power-Interest Matrix for Stakeholder (ST) Analysis*

| Stakeholder | Role | Position | Interpretative Rationale |
|---|---|---|---|
| ST3 | Director | Manage Closely | Highest authority and strongest interest in institutional direction and brand image. |
| ST1 | Nurse | Keep Informed | Direct implementers who understood day-to-day communication but not as final decision-makers. |
| ST5 | Media Staff | | |
| ST4 | Head of training | Keep Satisfied | Coordinating actors (doctors, nurses, hospital staff) with stronger structural influence than staff-level media executors. |
| ST2 | General Affair Manager | Monitor | Contextual observer who understood the organization, but was not directly responsible for the brand's KPI. |

Secondary data consisted of social media monitoring and institutional materials. Social media monitoring was included because brand meaning increasingly lives in digital visibility: recurring comments, reactions, testimonials, and public narratives can reveal how a hospital is being interpreted in everyday language. Institutional materials were used to contextualize the organization's history, values, and communication patterns. These sources allowed the study to compare articulated internal positioning with external public interpretation. The data were analysed using thematic analysis (Braun & Clarke, 2006). Initial coding was conducted across all interview transcripts and secondary materials. Codes were then grouped according to the three brand image benefit categories. From there, the analysis moved inductively and comparatively to identify which benefit dimension was consistently prioritized by stakeholders, and how the three dimensions interacted. Credibility was strengthened through cross-source comparison between interview data, digital feedback patterns, and institutional narratives.

## Results and Discussion

### Symbolic Benefit as the Primary Driver

Across the interviews, stakeholders repeatedly described the hospital's strength in terms of trust, social concern, and being "for the people," rather than in terms of superior medical prestige alone. Stakeholders linked trust to repeated positive experience and to figure-based moral credibility.

**Table 2**
*Selected Interview Responses Showing How Trust Was Constructed*

| Brand Image Benefit | Stakeholder | Interview Response |
|---|---|---|
| **Symbolic** | ST1 | "Our lower price still feels balanced to the quality patients receive. They (the patients) feel comfortable, and that builds trust." |
| | ST3 | "The owner positions himself as the patient's family. That keeps the brand relatable" |
| | ST4 | "People often say it feels good here and not complicated. I think that comes from good past experience." |
| | ST2 | "We do orient ourselves toward the community, in line with our vision and mission. We work very hard to make sure patients receive what they are entitled to" |

Table 2 shows that trust was explained through more than satisfactory service encounters. Stakeholders described that the hospital's legitimacy did not come mainly from being the most well-known service provider in the city, but from being seen as socially sympathetic, accessible, and unwilling to make sick people struggle unnecessarily. In a BPJS-dominated context, such meanings matter because the hospital is not evaluated only as a service provider, evaluated as an institutional actor within the wider moral economy of healthcare access. ST1 and ST4 emphasized comfort and simplicity, while ST2 and ST3 pointed to reputation, relational leadership, and the founder's social stance. This is why symbolic benefit became central. The hospital was interpreted not only as a place that provides treatment. ST5 reinforced this pattern by noting that some patients return because they have known the hospital since childhood.

**Table 3**
*Selected Interview Responses Showing Social Value as Symbolic Benefit*

| Brand Image Benefit | Stakeholder | Interview Response |
|---|---|---|
| **Symbolic** | ST2 | "The founder's vision is indeed to help the poor. Also, compared with other places, I think the process here is easier and more guided. Patients are not left confused about what they need to do or where they need to go" |
| | ST3 | "So whenever something happens, we feel more related to the patient, and we truly become pro-people, in line with what they need. If it were not for the current owner, this brand might not really be able to understand what patients want" |

These responses in Table 3 indicate that symbolic benefit was anchored in two major sources: trust based on prior experience and trust based on institutional figures. The first came from repeated patient encounters that felt easier, clearer, and more reassuring. The second came from the founder-owner figure, whose social vision still shaped how stakeholders understood the hospital's brand. This makes symbolic benefit especially important, because it explains why the hospital was seen as trustworthy even without being described as the strongest hospital in purely functional terms.

## Experiential and Functional Benefit as the Supporting Driver

Stakeholders consistently acknowledged that process simplicity, emotional comfort, and service clarity mattered a great deal. This pattern suggests that experiential and functional benefits worked as baseline expectations. They mattered because poor process and poor service would damage the brand. Yet stakeholders did not frame them as the decisive

explanation of why patients kept choosing the hospital. Distinctiveness emerged only when those operational qualities accumulated into a symbolic reading: this is a hospital that understands people, does not complicate care, and can therefore be trusted.

**Table 4**
*Selected Interview Responses on Experiential and Functional Benefits*

| Brand Image Benefit | Stakeholder | Interview Response |
|---|---|---|
| **Experiential** | ST1 | "Patients come back not only because of price. Sometimes it is because the process is not difficult." |
| | ST5 | "Compared with other places, the procedures here feel easier, and families are not heavily restricted." |
| **Functional** | ST3 | "Affordable does not always mean low price. It should still feel justified in relation to what the patient receives." |
| | ST2 | "We are well known for hemodialysis, and our CT scan is considered one of the strongest facilities in Jember." |

Table 4 shows the experiential benefit show that ease was a meaningful part of the patient journey. Stakeholders repeatedly used simple phrases such as "not complicated" and "easier," suggesting that positive experience was interpreted less as luxury and more as relief. The functional benefit point to affordability and recognizable service capability. Affordability was framed as fairness, not cheapness. Taken together, experiential and functional benefits acted as supporting proof that kept the symbolic promise believable. Respond indicates that experiential benefit was not always framed as luxury or convenience in a commercial sense. Instead, it was framed as humane aspects. Patients and families experienced the hospital as easier, warmer, and less restrictive than other institutions. In this context, "ease" carried emotional weight because it reduced stress during illness.

## Trust as Behavioral Outcome

The final theme analysis shows that trust did not remain at the level of perception alone. It also appeared in behavior. Stakeholders described how trust became visible through patient recommendations, testimonials, and repeat visits. This is particularly meaningful because it suggests that symbolic benefit translates into concrete market consequences. These responses suggest that trust functioned as more than a passive brand association. In that sense, word of mouth and repeat visits can be understood as manifestations of trust.

**Table 5**
*Selected Interview Responses on Experiential and Functional Benefits*

| Brand Image Benefit | Stakeholder | Interview Response |
|---|---|---|
| **Symbolic** | ST5 | "They are often proud if they succeed in bringing someone here. So yes, recommendations really do come from testimonials" |
| | ST3 | "The people of Jember always come first. We are also known for not rejecting patients. Because they are satisfied and treated well, they come back again" |

## Limitation and Recommendations

This study has several limitations that should be acknowledged. First, the scope of participants was relatively limited, which may restrict the extent to which the findings can represent broader audiences. While the results provide valuable insights into the phenomenon under investigation, future studies are encouraged to involve a larger and more diverse sample to enhance the breadth, robustness, and generalisability of the findings across different demographic and contextual settings.

Furthermore, future research could move beyond conventional social media listening by incorporating Instagram data scraping through cloud-based APIs. This approach would enable researchers to systematically collect and analyse public data, including posts, comments, hashtags, and engagement metrics. By transforming social media observations into structured and quantifiable datasets, researchers can generate more concrete evidence, identify patterns at a larger scale, and provide stronger empirical support for understanding audience behaviour and digital engagement trends.

## Conclusion

At the beginning of several interviews, stakeholders spoke in the language of service competition, implying that good service was central for surviving against other hospitals. However, as the interviews developed, the logic of distinctiveness shifted. Stakeholders did not ultimately describe the hospital as the city's most advanced or premium provider. Instead, they described it so as not to make illness feel heavier than it already is. This distinction is strategically important in a UHC setting. When many hospitals can claim adequate service, symbolic meaning can become the sharper basis of difference. The focus from service competition to symbolic positioning was also visible in how stakeholders interpreted market feedback. Rather than celebrating service as an end in itself, they treated service as part of a larger promise: making healthcare feel more humane, affordable, and socially fair. In that sense, experiential and functional benefits were not rejected. They were reassembled into a broader symbolic meaning. The brand gained strength because it made ordinary patients feel seen, helped, and protected.

In healthcare systems where access, procedure, and public expectation are shaped by large-scale insurance schemes, the image of care providers can be influenced by meanings that circulate beyond the provider itself. Private hospitals, therefore, may need to think not only about service competition, but also about symbolic benefits: what moral meaning does the brand carry, what kind of trust does it invite, and how does it interpret the realities of the community it serves. The study is limited by its single-case design and its focus on internal stakeholders rather than direct patient feedback. However, that focus is also the study's contribution, because it reveals how brand strategy is interpreted by the actors who absorb patient feedback, navigate UHC realities, and shape communication from within the organization. Future research could compare multiple hospitals, include patient and policy perspectives, or examine whether similar symbolic dynamics appear in other UHC contexts. For practice, healthcare facilities under UHC, good service is expected, but trust can become a deeper differentiator. Hospitals may remain strategically strong not only by performing well, but by being perceived as humane, socially aligned, and genuinely committed to making care easier to reach.

## Ethical Considerations

All participants (stakeholders) gave informed consent, and their anonymity was protected. The study adhered to ethical standards for educational research set by the university.

## Declaration of Generative AI and AI-Assisted Technologies in the Writing Process

The author declares that no AI or AI-assisted technologies have been used to generate, refine, or correct the content in the manuscript. The ideas, design, procedures, findings, analyses, and discussion are originally written and derived from careful and systematic conduct of the research.

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