

EFFECT OF PATIENT-CENTERED CARE ON SERVICE QUALITY AND SATISFACTION LEVEL OF BPJS INPATIENTS IN BAPTIST HOSPITAL BATU

JAM

16,1

Received, April 2017

June 2017

Revised, September 2017

December 2017

Accepted, February 2018

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Abstract: This study aims to determine the effect of PCC implementation and its relation to patient satisfaction, either directly or indirectly, with the quality of service as mediating factor. This research is an explanatory research with cross-sectional approach. This study aims to determine the effect of (1) PCC implementation, (2) technical service quality, (3) functional service quality, and (4) patient satisfaction level. The study was conducted during March-April 2017 in inpatient unit of Baptism Batu Hospital, with the sample of 100 people. Data were collected using questionnaires measuring the perception of patients using a 5-point *Likert* scale. Data were analyzed using SMART-Partial Least Square. PCC has a direct effect on service quality, but it was not significant. PCC had an indirect effect on patient satisfaction, especially through functional service quality. Overall, functional service quality directly affected patient satisfaction with the greatest total effect. PCC should be implemented with respect to service quality to create patient satisfaction.

Keywords: Patient-Centered Care, service quality, technical quality, functional quality, patient satisfaction



Journal of Applied
Management (JAM)
Volume 16 Number 1,
March 2018
Indexed in Google Scholar

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DOI: [http://dx.doi.org/
10.21776/ub.jam.2018.016.
01.11](http://dx.doi.org/10.21776/ub.jam.2018.016.01.11)

After Baptist Hospital passed the accreditation in June 2014, there was a decrease in the level of patient satisfaction towards the laboratory staff, i.e. patient satisfaction towards the laboratory staff's skills (from 94% to 80%), and patient satisfaction towards the laboratory staff's politeness, courtesy, and hospitality (from 94% to 85%). Similarly, in the nursing unit, patient satisfaction towards the laboratory staff's politeness, courtesy,

and hospitality also decreased from 92% to 82%; patient satisfaction towards the laboratory staff's responsiveness also decreased from 94% to 82%; patient satisfaction towards the laboratory staff's skills also decreased from 98% to 82%; and patient satisfaction towards the laboratory staff's communication also decreased from 92% to 80%. Patient satisfaction towards overall service declined from 94% to 82%. Patient satisfaction decreased when the hospital improved its performance according to Patient-Centered Care (PCC) guidelines set by Hospital Accreditation Commission (KARS).

According to Hansemark and Albinsson (2004), satisfaction is the overall behavior of consumers toward a service provider, or an emotional reaction to what they receive compared to their

expectations, once their needs, goals, and desires have been met. Homburg et al. (2006) stated that satisfaction assessment is strongly influenced by cognition and affection. The study of cognition is primarily related to expectation or confirmation/disconfirmation paradigm stating that expectations stem from consumer trust with respect to the level of performance of a product/ service to be received (Oliver, 1980). Satisfaction is “post-choice evaluative judgment”. If perceived performance exceeds consumer’s expectation (a positive disconfirmation), the consumer will be satisfied, but if this is below the expectation (a negative disconfirmation), the consumer will be dissatisfied (Spreng et al., 1996). In this case, a gap in the implementation of PCC at Baptist Hospital Batu occurred due to employee performance received by patients which were not in accordance with the expectations of patients.

This research aims to reveal the effect of PCC after the enactment of JKN and its relation with patient satisfaction, either directly or indirectly; service quality was used as mediating factor. Inpatient unit was taken as a research object because inpatient unit is a service that can illustrate the PCC implementation more clearly. This study aims to know the effect of PCC on service quality model proposed by Gronroos (1988). This model divided service quality into two major areas or dimensions: technical service quality and functional service quality (Aghamolaei et al., 2014).

This research can be used by Baptist Hospital to know the implementation of PCC in BPJS inpa-

tient unit and to know the constraints in achieving patient satisfaction. If it is not conducted, then the hospital management cannot know constraints in PCC implementation and how to find the solution.

METHOD

This research is an explanatory research with cross-sectional approach. This study aims to determine the effect of the variables studied, namely: (1) the implementation of PCC, (2) technical service quality, (3) functional service quality, and (4) the level of patient satisfaction. This study was conducted from March to April 2017 at inpatient unit of Baptist Hospital Batu. 100 people were taken as the sample of this study. Data was collected using questionnaire measuring patient’s perceptions using a 5-point *Likert* scale. Data were analyzed using SMART-Partial Least Square (PLS).

RESULTS

This research found the characteristics of respondents that can influence the research results, which are described in Table 1. The majority of patients were women, aged 46-65 years, graduates of secondary education and below, and in middle-class income. The frequency distribution of respondents’ answers is described in Tables 2, 3, 4, and 5. Furthermore, the results of the PLS analysis are described in Figures 1, 7, 8, and 9. The results of hypothesis testing are described in Tables 10, 11 and 12. The goodness of Fit Model is described in Table 13.

Table 1 Characteristics of Respondents

	Characteristics of Respondents	Number	Percentage
Sex	• Male	49	49.0%
	• Female	51	51.0%
Address	• Batu	48	48.0%
	• Pujon	2	2.0%
	• Bumiaji	12	12.0%
	• Malang Regency	15	15.0%
	• Junrejo	16	16.0%
	• Others	7	7.0%
Age	• ≤ 25 years old	11	11.0%
	• 26 - 45 years old	20	20.0%

Effect of Patient-Centered Care on Service Quality and Satisfaction Level of BPJS

Characteristics of Respondents		Number	Percentage
Sex	• 46 - 65 years old	53	53.0%
	• > 65 years old	16	16.0%
Length of hospitalization	• Two days	24	24.0%
	• Three days	42	42.0%
	• Four days	29	29.0%
	• Five days or more	5	5.0%
Last Education	• Elementary School	36	36.0%
	• Junior High School	3	3.0%
	• Senior High School	31	31.0%
	• Undergraduate or above	30	30.0%
Income	• < 1 million rupiahs	2	2.0%
	• 1 - 2 million rupiahs	15	15.0%
	• 2 - 3 million rupiahs	17	17.0%
	• 3 - 4 million rupiahs	50	50.0%
	• > 4 million rupiahs	16	16.0%

Source: Processed questionnaire data, 2017

Table 2 Frequency Distribution of Respondent's Response toward the Implementation of PCC

	Respondent's Answer						Mean
	SS	S	N	TS	STS		
PCC1.1	F	20	50	22	3	5	3.77
	%	20.0%	50.0%	22.0%	3.0%	5.0%	
PCC1.2	F	23	46	24	4	3	3.82
	%	23.0%	46.0%	24.0%	4.0%	3.0%	
PCC1.3	F	18	52	22	5	3	3.77
	%	18.0%	52.0%	22.0%	5.0%	3.0%	
Mean of Dimension							3.79
PCC2.1	F	19	52	17	10	2	3.76
	%	19.0%	52.0%	17.0%	10.0%	2.0%	
PCC2.2	F	24	49	16	9	2	3.84
	%	24.0%	49.0%	16.0%	9.0%	2.0%	
PCC2.3	F	20	49	18	10	3	3.73
	%	20.0%	49.0%	18.0%	10.0%	3.0%	
Mean of Dimension							3.78
PCC3.1	F	27	44	20	6	3	3.86
	%	27.0%	44.0%	20.0%	6.0%	3.0%	
PCC3.2	F	28	47	16	5	4	3.90
	%	28.0%	47.0%	16.0%	5.0%	4.0%	
PCC3.3	F	27	48	17	5	3	3.91
	%	27.0%	48.0%	17.0%	5.0%	3.0%	
Mean of Dimension							3.89
PCC4.1	F	33	40	15	8	4	3.90
	%	33.0%	40.0%	15.0%	8.0%	4.0%	

	Respondent's Answer						Mean
	SS	S	N	TS	STS		
<i>PCC4.2</i>	F	35	38	15	7	5	3.91
	%	35.0%	38.0%	15.0%	7.0%	5.0%	
<i>PCC4.3</i>	F	30	47	10	11	2	3.92
	%	30.0%	47.0%	10.0%	11.0%	2.0%	
Mean of Dimension							3.91
<i>PCC5.1</i>	F	24	45	19	8	4	3.77
	%	24.0%	45.0%	19.0%	8.0%	4.0%	
<i>PCC5.2</i>	F	24	50	16	6	4	3.84
	%	24.0%	50.0%	16.0%	6.0%	4.0%	
<i>PCC5.3</i>	F	25	51	14	7	3	3.88
	%	25.0%	51.0%	14.0%	7.0%	3.0%	
Mean of Dimension							3.83
<i>PCC6.1</i>	F	22	52	14	9	3	3.81
	%	22.0%	52.0%	14.0%	9.0%	3.0%	
<i>PCC6.2</i>	F	31	43	14	10	2	3.91
	%	31.0%	43.0%	14.0%	10.0%	2.0%	
<i>PCC6.3</i>	F	32	37	20	7	4	3.86
	%	32.0%	37.0%	20.0%	7.0%	4.0%	
Mean of Dimension							3.86
<i>PCC7.1</i>	F	21	46	19	8	6	3.68
	%	21.0%	46.0%	19.0%	8.0%	6.0%	
<i>PCC7.2</i>	F	19	50	16	10	5	3.68
	%	19.0%	50.0%	16.0%	10.0%	5.0%	
<i>PCC7.3</i>	F	12	60	18	5	5	3.69
	%	12.0%	60.0%	18.0%	5.0%	5.0%	
Mean of Dimension							3.68
<i>PCC8.1</i>	F	21	44	23	8	4	3.70
	%	21.0%	44.0%	23.0%	8.0%	4.0%	
<i>PCC8.2</i>	F	20	49	16	12	3	3.71
	%	20.0%	49.0%	16.0%	12.0%	3.0%	
<i>PCC8.3</i>	F	19	50	14	13	4	3.67
	%	19.0%	50.0%	14.0%	13.0%	4.0%	
<i>PCC8.4</i>	F	18	53	18	6	5	3.73
	%	18.0%	53.0%	18.0%	6.0%	5.0%	
Mean of Dimension							3.70

Source: Processed questionnaire data, 2017

Table 3 Frequency Distribution of Respondent's Response toward the Technical Service Quality

	Respondent's Answer						Mean
	SS	S	N	TS	STS		
KT1.1	F	22	65	6	6	1	4.01
	%	22.0%	65.0%	6.0%	6.0%	1.0%	
KT1.2	F	23	62	10	4	1	4.02
	%	23.0%	62.0%	10.0%	4.0%	1.0%	
Mean of Dimension							4.02
KT2.1	F	25	58	13	4	0	4.04
	%	25.0%	58.0%	13.0%	4.0%	0.0%	
KT2.2	F	23	61	12	4	0	4.03
	%	23.0%	61.0%	12.0%	4.0%	0.0%	
Mean of Dimension							4.04
KT3.1	F	25	65	7	3	0	4.12
	%	25.0%	65.0%	7.0%	3.0%	0.0%	
KT3.2	F	25	58	15	2	0	4.06
	%	25.0%	58.0%	15.0%	2.0%	0.0%	
Mean of Dimension							4.09
KT4.1	F	30	53	11	5	1	4.06
	%	30.0%	53.0%	11.0%	5.0%	1.0%	
KT4.2	F	35	48	15	1	1	4.15
	%	35.0%	48.0%	15.0%	1.0%	1.0%	
Mean of Dimension							4.11
KT5.1	F	39	40	15	6	0	4.12
	%	39.0%	40.0%	15.0%	6.0%	0.0%	
KT5.2	F	32	41	22	5	0	4.00
	%	32.0%	41.0%	22.0%	5.0%	0.0%	
Mean of Dimension							4.06
KT6.1	F	50	35	13	2	0	4.33
	%	50.0%	35.0%	13.0%	2.0%	0.0%	
KT6.2	F	44	36	14	6	0	4.18
	%	44.0%	36.0%	14.0%	6.0%	0.0%	
Mean of Dimension							4.26

Source: Processed questionnaire data, 2017

Table 4 Frequency Distribution of Respondent's Response toward the Functional Service Quality

	Respondent's Answer						Mean
	SS	S	N	TS	STS		
KF1.1	F	33	45	15	6	1	4.03
	%	33.0%	45.0%	15.0%	6.0%	1.0%	
KF1.2	F	31	46	15	6	2	3.98
	%	31.0%	46.0%	15.0%	6.0%	2.0%	
Mean of Dimension							4.01
KF2.1	F	25	45	16	11	3	3.78
	%	25.0%	45.0%	16.0%	11.0%	3.0%	
KF2.2	F	26	43	16	13	2	3.78
	%	26.0%	43.0%	16.0%	13.0%	2.0%	
Mean of Dimension							3.78
KF3.1	F	32	46	13	7	2	3.99
	%	32.0%	46.0%	13.0%	7.0%	2.0%	
KF3.2	F	33	48	12	5	2	4.05
	%	33.0%	48.0%	12.0%	5.0%	2.0%	
Mean of Dimension							4.02
KF4.1	F	39	43	15	3	0	4.18
	%	39.0%	43.0%	15.0%	3.0%	0.0%	
KF4.2	F	42	37	14	5	2	4.12
	%	42.0%	37.0%	14.0%	5.0%	2.0%	
Mean of Dimension							4.15
KF5.1	F	43	27	14	13	3	3.94
	%	43.0%	27.0%	14.0%	13.0%	3.0%	
KF5.2	F	50	21	17	9	3	4.06
	%	50.0%	21.0%	17.0%	9.0%	3.0%	
Mean of Dimension							4.00
KF6	F	69	21	7	2	1	4.55
	%	69.0%	21.0%	7.0%	2.0%	1.0%	

Source: Processed questionnaire data, 2017

Table 5 Frequency Distribution of Respondent's Response toward Inpatient Satisfaction

	Respondent's Answer						Mean
	SS	S	N	TS	STS		
K1	F	71	29	0	0	0	4.71
	%	71.0%	29.0%	0.0%	0.0%	0.0%	
K2	F	74	23	3	0	0	4.71
	%	74.0%	23.0%	3.0%	0.0%	0.0%	

Source: Processed questionnaire data, 2017

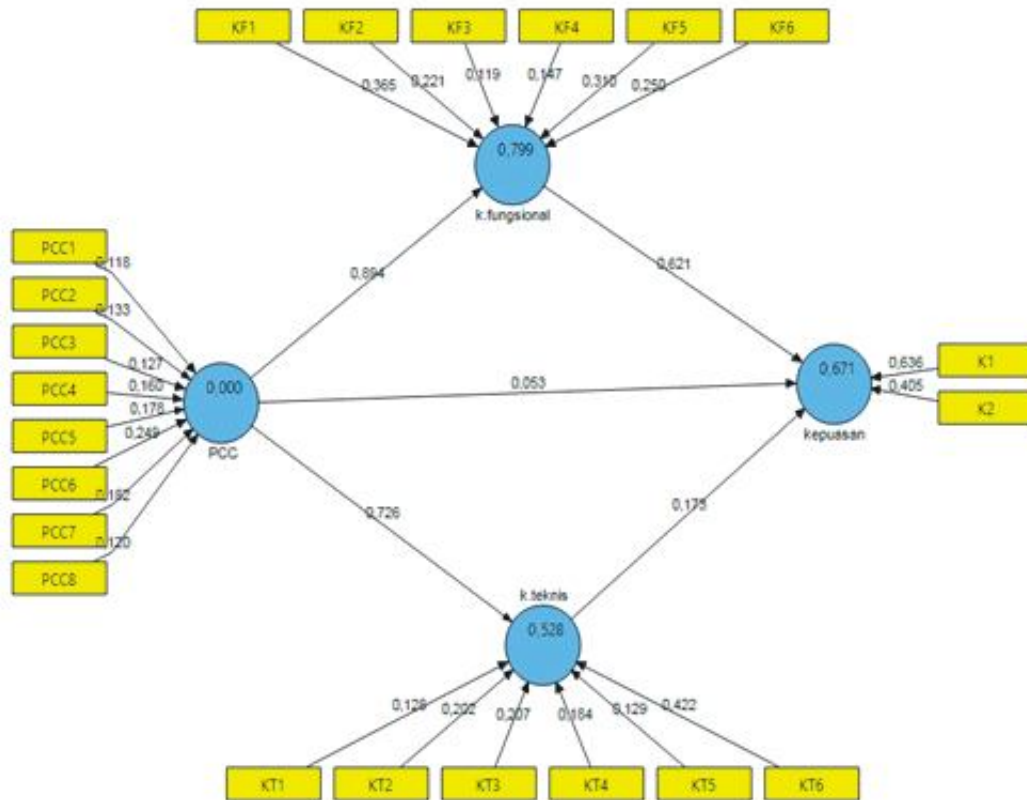


Figure 1 Path Diagram of Structural Equation with PLS Approach Using Software Smart-PLS

Table 6 The Effect of Dimension Forming PCC Implementation on Variable PCC Implementation

Variable	Indicator	Weight of Indicator
PCC Implementation	PCC1	0.118*
	PCC2	0.132*
	PCC3	0.127*
	PCC4	0.159*
	PCC5	0.178*
	PCC6	0.249*
	PCC7	0.182*
	PCC8	0.120*

Source: Processed questionnaire data, 2017

Table 7 The Effect of Dimension Forming Technical Service Quality on Variable Technical Service Quality

Variable	Indicator	Weight of Indicator
Technical Service Quality	KT1	0.127*
	KT2	0.202*
	KT3	0.207*
	KT4	0.184*
	KT5	0.129*
	KT6	0.422*

Source: Processed questionnaire data, 2017

Table 8 The Effect of Dimension Forming Functional Service Quality on Variable Functional Service Quality

Variable	Indicator	Weight of Indicator
Functional Service Quality	KT1	0.127*
	KF1	0.364*
	KF2	0.221*
	KF3	0.119*
	KF4	0.147*
	KF5	0.309*
	KF6	0.249*

Source: Processed questionnaire data, 2017

Table 9 The Effect of Dimension Forming Patient Satisfaction on Variable Patient Satisfaction

Variable	Indicator	Weight of Indicator
Patient Satisfaction	K1	0.636*
	K2	0.405*

Source: Processed questionnaire data, 2017

Table 10 Results of Direct Effect Hypothesis Testing

Exogenous	Endogenous	Original Sample (O)	Standard Error (STERR)	T Statistics (O/STERR)
PCC	KF	0.894	0.026	33.763*
PCC	KT	0.726	0.051	14.349*
PCC	K	0.053	0.172	0.307
KF	K	0.621	0.133	4.679*
KT	K	0.173	0.079	2.168*

Source: Processed questionnaire data, 2017

Table 11 Results of Indirect Effect Hypothesis Testing

Exogenous	Mediator	Endogenous	Original Sample (O)	T Statistics (O/STDEV)
PCC	KF	K	0.555	4.635
PCC	KT	K	0.126	2.144

Source: Processed questionnaire data, 2017

Table 12 Results of Direct, Indirect dan Total Effect Hypothesis Testing

Exogenous	Mediator	Endogenous	Direct	Indirect	Total
PCC		KF	0.894*		0.894
PCC		KT	0.726*		0.726
PCC	KF	K	0.053	0.555*	0.608
PCC	KT	K	0.053	0.126*	0.179
KF		K	0.621*		0.621
KT		K	0.173*		0.173

Note: * (Significant)

PCC : PCC Implementation

KF : Functional Service Quality

KT : Technical Service Quality

K : Satisfaction

Table 13 Table of Goodness of Fit Model

Variable	R ²
Technical Service Quality	0.528
Functional Service Quality	0.799
Patient Satisfaction	0.671
$Q^2 = 1 - \{(1 - R_1^2) * (1 - R_2^2) * (1 - R_3^2)\}$ $= 1 - \{(1 - 0.528) * (1 - 0.799) * (1 - 0.671)\}$ $= 0.969$	

Source: Processed questionnaire data, 2017

From PLS analysis, it was found some things as follows:

a. Equation 1

$$KF = 0.894 PCC$$

The coefficient of a direct effect of PCC implementation on functional service quality amounted to 0.894*, meaning that the implementation of PCC had a positive and significant effect on functional service quality.

b. Equation 2

$$KT = 0.726 PCC$$

The coefficient of a direct effect of PCC implementation on technical service quality amounted to 0.726*, meaning that PCC implementation had a positive and significant effect on technical service quality.

c. Equation 3

$$K = 0.053 PCC + 0.621 KF + 0.173 KT$$

1. Coefficient of direct effect of PCC implementation on patient satisfaction amounted to 0.053, meaning that PCC implementation had positive but not significant effect on patient satisfaction.

2. The coefficient of a direct effect of functional service quality on patient satisfaction amounted to 0.621*, meaning that functional service quality had a positive and significant effect on patient satisfaction.

3. The coefficient of a direct effect of technical service quality on patient satisfaction amounted to 0.173*, meaning that

technical service quality had a positive and significant effect on patient satisfaction.

4. The coefficient of an indirect effect of PCC implementation on patient satisfaction through functional service quality amounted to 0.555*, meaning that PCC implementation had a positive and significant effect on patient satisfaction through functional service quality.

5. The coefficient of an indirect effect of PCC implementation on patient satisfaction through technical service quality amounted to 0.126*, meaning that PCC implementation had a positive and significant effect on patient satisfaction through technical service quality.

d. Dominant Effect

The analysis results of this research informed that the variable that had the greatest total effect on patient satisfaction was functional service quality, with the total effect of 0.621. Functional service quality was the most influential variable; in other words, it had the most dominant effect on patient satisfaction.

e. From the evaluation of Goodness of Fit Model, it was found that:

R-square of variable technical service quality amounted to 0.528 or 52.8%, meaning that the contribution of PCC implementation to the technical service quality amounted to 52.8%, while the rest of 47.2% was the contribution of other variables which were not discussed in this research. R-square of variable functional service quality amounted to 0.799 or 79.9%, meaning that the contribution of PCC implementation to functional service quality amounted to 79.9%, while the rest of 20.1% was the contribution of other variables which were not discussed in this research. R-square of variable patient satisfaction amounted to 0.671 or 67.1%, meaning that the diversity of patient satisfaction was explained by PCC implementation, technical quality, and functional quality variable 67.1%; in other words, the contribution of PCC

implementation, technical servicequality, and functional servicequality to patient satisfaction amounted to 67.1%, while the rest of 32.9% was the contribution of other variables whichwere not discussed in this study. Furthermore, Q-Square predictive relevance (Q^2) of variable patient satisfaction amounted to 0.969 or 96.9%. This showed that the diversity of patient satisfaction was explained by the overall model of 96.9%; in other words, the contribution of PCC implementation, technical servicequality, and functional servicequality as a whole to patient satisfactionamounted to 96.9%, while the rest of 3.1% was contributed by another variable which was not discussed in this study.

DISCUSSIONS

The characteristics of patients affected this research indirectly. It was found that most of the respondents were female (51.0%), came from Batu (48.0%), aged 46-65 years old (53.0%), being hospitalized for three days (42.0%), graduates of senior high school or below (70.0%), and have monthly income of 3 -4 million rupiahs (50.0%).

Kotler (1997) stated that the level of education affects consumer perceptions of goods or services purchased. High consumer's level of education leads to high consumer's satisfaction level. In this case, BPJS inpatients in Baptist Hospital Batuwere mostly graduates of high school or below, so that they were easier to be satisfied. In addition, according to studies conducted by Kellaris and Mantel (1994) and Grewal et al. (2003), female consumersare more patient than male consumers, thus this is likely to affect consumer satisfaction towards a service. Most of BPJS inpatients in Baptist Hospital Batuwere women, so they were satisfied more easily. Afzal et al. (2014) suggest that older patients and patients with low level of education are easily satisfied; and patients with low-income levelare more easily satisfied with a health-care facility than younger patients, patients with higher education level, and patients with higher income level. Musunuru and Vivek (2014) argue that income level affects patient satisfaction. Most of BPJS inpatients in Bap-

tist Hospital Batu wereold and had the low level of education so that they were more easily satisfied. The income level of the most of BPJS inpatients in Baptist Hospital Batuwas in middle class(ranges from Rp 3-4 million), so this is a factor that can decrease patient satisfaction. The increase in income level in Batu is likely to be supported by the revenue of Batu city as one of regional national and international tourism destinations, so as to boost the economic capacity of its citizens.

From the eight dimensions of PCC, coordination of care is considered a factor affecting the implementation of most dominantly, while patient preference indicators are considered the least influential factor in PCC formation. Coordination of care includes the coordination of hospital staff both medical and non-medical in clinical services, coordination of supportive and supplementary service, and coordination of patient care on the front lines. Meanwhile, the activities in patient preferences include services performed respectfully toward patients, focus on improving the life quality of patients, always involving patientsin making a decision together after giving information to patients clearly, and serving patients with respect, appreciation, and sensitivity to cultural values adopted. This indicated that BPJS patients in Baptist Hospital Batudid notrealizethat they have a right to be respected as individuals, right to be involvedin making decisions with doctors, and right to be respected (in terms of their culture). This might be due to patient's low level of education; most of the patients were graduates of high school or below. Patients expected good teamwork in their health-care(from the beginning to the end of their health-care in Baptist Hospital Batu).

The direct effect of PCC implementation on patient satisfaction was not significant. However, the implementation of PCC had an indirect and significant effect on patient satisfaction, especially through the mediation of functional quality. PCC, technical quality, and functional quality simultaneously contributed 67.1% to patient satisfaction; the remaining 32.7% came from other variables which were not included in the study. Simultaneously, the diversity of patient satisfaction was explained

by this structural model amounted to 96.9%, while 3.1% was the contribution of other variables that were not involved in this study; therefore, this research is good to assess all factors that affect patient satisfaction. Service in the form of PCC should be performed according to the functional quality criteria contained in literature study which was conducted by Hamed and De Lusignan (2013). It is said that functional quality is determined by human resources and relationships. Human resources required are people that can interact with patients well, ie people who have interpersonal skills. The relation is the collaboration between various parties who can always evaluate the quality and safety of services in terms of its function. In this case, if PCC is implemented with high-quality human resources and good relations as mentioned above, the functional quality will be improved. Otherwise, if it is not carried out according to the above criteria, the functional quality will not be improved. If PCC is implemented in accordance with criteria that support the functional quality, patient satisfaction also will ultimately be improved. Otherwise, if it is not carried out according to the above criteria that support the functional quality, patient satisfaction will not be improved.

Overall, from all variables studied, i.e. PCC implementation, functional service quality, and technical service quality, the variable which had the biggest effect on patient satisfaction was functional service quality, with the total effect of 0.621, while variable which had the smallest effect on patient satisfaction was technical service quality. This is contrary to the finding of the previous research which was conducted by Carman (2000) that technical quality is more important than functional quality, although both are equally significant. This might happen because the education level of patients in Baptist Hospital Batu was relatively low, so the patients were still more concerned with functional patients quality than technical patients quality.

Other variables that were not included in this research are patient factors, i.e. type of disease, medical needs, education, and access to medical information (Yu et al., 2016). Chen et al. (2016) mentioned that those are physical status, psychological status, and expectations; those are other factors

outside which were not studied in this research. In addition, the same study also mentions that government factors include social environment, health policy, medical insurance, and welfare level; those are factors that influence patient satisfaction outside of variables in this research. According to Gronroos (1984), advertising and pricing can affect patient satisfaction. Research which was conducted by Aditi (2009), Masood et al. (2009) in Rahman and Osmangani (2015), and Singh (2015) also emphasized price as a determinant of satisfaction, but this is not found in BPJS patients if there are no additional costs for patients. Employee's job satisfaction is also considered affect patient satisfaction (Petrochuk, 1999). Channel chosen by patients i.e. internet, call centers, and other technologies can affect patient satisfaction (Sankar et al. 2003; Sousa and Voss, 2006; Cassab and MacLachlan, 2009; Larivie're et al., 2011), but this was less influential in this study because the inpatients used BPJS facility, so that the channel used is the same.

This study found that PCC dimension that should be improved is coordination of care. This can be done by maximizing the functionality of the case manager, the integrated medical record, and the clinical pathway. It has not been run optimally by Baptist Hospital. The low influence of patient preference dimension still needs to be considered a challenge in the future by hospital management to be able to overcome communication gap that occurs between doctor and patient because socioeconomic change may occur, especially patient's education level several in the future. It is expected that Baptist Hospital Batu can maintain patient satisfaction by continuing to implement PCC. Patient-Centered Care should still be implemented with a functional quality approach. The average number of patients who are satisfied with the quality of hospital services should be maintained and improved in the future in order to maintain patient satisfaction.

The limitation of this research lies in the research design; the research designed used (cross-sectional research design) caused this study to describe a condition at a particular time only. The objects of this research were homogeneous (inpatients); therefore, it could not describe BPJS patients in the

hospital as a whole. There are still other factors that influence patient satisfaction outside the variables studied in this research. The result of this research maybe different if it is conducted in other hospitals.

CONCLUSION AND SUGGESTION

Patient-Centered Care is essential to building the quality of BPJS inpatient unit of Baptist Hospital Batu; it indirectly resulted in patient satisfaction, especially through functional service quality at Baptist Hospital Batu. Patient-Centered Care had no significant effect on patient satisfaction without going through variable service quality, especially functional service quality. Based on the results of this study, overall, functional service quality had the greatest effect on BPJS patient satisfaction in inpatient unit of Baptist Hospital Batu.

Patient-Centered Care should be implemented by taking into account the quality of service in order to be able to create patient satisfaction, especially in the form of coordination of care, which is the most influential factor for PCC. PCC also should pay attention to functional service quality, i.e. professionalism, high-quality, politeness, friendliness, responsiveness, honesty, correctives, and maintaining a good image of Baptist Hospital Batu.

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