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Urban Reality Construction of BPJS Services: Comparative Study at Mangusada Hospital and Clinic

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ABSTRACT

This study analyzes how urban communities construct social reality regarding BPJS Health services through direct experiences in two different healthcare institutions, namely RSUD Mangusada and Mengwi I Clinic, Badung Regency. The research is grounded in the dynamics of urban society characterized by high mobility, social diversity, and strong expectations for public services that are fast, efficient, and humane. A qualitative approach with a comparative design was employed to explore the perceptions of patients, health workers, and institutional managers. Data were collected through in-depth interviews, participatory observations, and documentation. The findings reveal differences in social constructions between the two institutions. RSUD Mangusada is often perceived as slow, bureaucratic, and less communicative, particularly in relation to long queues, extended waiting times for medication, and complaint mechanisms that lack transparency. In contrast, Mengwi I Clinic is considered more efficient, friendly, and closer to the community, with orderly queues, open communication, and services that adapt to local needs. Factors such as staff attitudes, transparency of information, accessibility, and the alignment of facilities with patient expectations play a crucial role in shaping public perceptions. Balinese cultural values that emphasize politeness and harmony further strengthen the meaning of health services, making social interaction an essential element in building trust toward healthcare institutions. These findings affirm that perceptions of BPJS services are not merely the result of formal structures but are socially constructed through collective experiences and repeated interactions.

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INTRODUCTION

Urban society in Badung Regency must be defined with precision to avoid conceptual ambiguity. In this study, the term "urban" does not merely refer to geographic location but to the socio-economic and cultural characteristics of the population. Pawastra et al. (2025) emphasize that urban society in Badung is shaped by high mobility, diverse social interactions, and lifestyles oriented toward modern service consumption. The coexistence of local residents and migrants, the prevalence of service-based employment, and expectations for efficiency and quality in public services including healthcare are central features of this urban condition. Thus, "urban" here is understood as a sociological

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category that reflects the transformation of Badung into a tourism-driven urbanized area, where healthcare services are evaluated not only by their accessibility but also by their alignment with modern expectations of speed, reliability, and transparency.

The rapid urbanization of Badung has generated complex demands for healthcare services. Land-use changes, with agricultural areas increasingly converted into dense residential zones, have intensified the need for accessible and efficient healthcare. Within this context, BPJS Kesehatan faces mounting challenges in meeting the expectations of urban populations accustomed to fast and reliable service delivery. Dissatisfaction often arises when the perceived quality of care does not align with the contributions paid, manifesting in complaints about long queues, limited medication availability, and administrative complexity (Rahmah et al., 2025; Arimbi et al., 2022). These complaints are not isolated but represent a broader social reality in which patients construct their perceptions of BPJS services through repeated interactions with healthcare institutions.

The purpose of this research is to analyze how urban society constructs its social reality regarding BPJS healthcare services in Badung. The analytical focus is not limited to measuring satisfaction or dissatisfaction but rather to examining the process of social construction as theorized by Berger & Luckmann (1996). Their framework—externalization, objectivation, and internalization—provides a lens to understand how repeated interactions between patients, healthcare providers, and institutional structures shape collective perceptions of BPJS services. Externalization refers to the expression of patient complaints and expectations; objectivation occurs when these expressions are institutionalized through hospital procedures and collective discourse; internalization takes place when patients adopt these institutionalized meanings into their own perceptions of healthcare reality. By applying this framework, the study moves beyond descriptive accounts of satisfaction to reveal the mechanisms through which social realities are constructed.

The comparative design of this study, focusing on RSUD Mangusada and Mengwi I Clinic, is deliberate. RSUD Mangusada represents a secondary referral hospital with advanced facilities and complex administrative procedures, while Mengwi I Clinic embodies primary care with simpler, more direct service delivery. This contrast highlights how different institutional contexts influence the construction of patient experiences. At RSUD Mangusada, BPJS patients often encounter longer waiting times and layered referral systems but gain access to specialized care and modern equipment. In contrast, Mengwi I Clinic offers faster administrative processes and immediate basic services, though with limited specialization. The comparative logic lies in demonstrating how institutional scale and service complexity shape distinct realities for BPJS users (Girsang et al., 2023). This, the study seeks to prove that differences in institutional context lead to differences in the processes of externalization, objectivation, and internalization of patient experiences.

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To strengthen the analysis, this study integrates Berger and Luckmann's social construction theory with insights from public service sociology and medical sociology. Public service sociology emphasizes the relationship between the state and citizens in ensuring accessibility, equity, and accountability in healthcare delivery (Suryawati, 2024; Kurniawan et al., 2024). Medical sociology highlights how patients' interpretations of health services are influenced not only by clinical outcomes but also by social, cultural, and relational factors (Purba & Meilianna, 2023; Lubis, 2023). Moreover, differences in socio-economic background often shape how patients evaluate BPJS services: lower-income groups tend to value affordability and access, while higher-income groups emphasize comfort, speed, and choice of facilities (Djunawan et al., 2022; Marhenta et al., 2018). The integration of these perspectives ensures that the analysis moves beyond descriptive accounts of satisfaction to a deeper understanding of how social realities are constructed through interaction, institutional structures, and symbolic meanings.

Several previous studies provide important context. Singgih et al. (2023) investigated service quality in a private hospital in Bogor and found that dimensions such as tangibility, reliability, responsiveness, assurance, and empathy still required improvement to satisfy BPJS participants. Their findings highlight that service quality is not merely technical but involves relational and communicative aspects that shape patient perceptions. Andini et al. (2023), in their quantitative study of inpatient services in Depok, concluded that there was no significant difference in satisfaction between BPJS and non-BPJS patients. However, their data revealed nuanced disparities across service dimensions, with BPJS patients reporting lower satisfaction in responsiveness and assurance. This suggests that while hospitals may claim equal treatment, patients' lived experiences reveal subtle forms of differentiation. Both studies underscore the importance of analyzing service quality as a socially constructed reality rather than a purely objective measure.

The broader context of public service reform also informs this study. Rohmat & Elisanti (2021) analyzed bureaucratic changes during the COVID-19 pandemic and emphasized the shift from conventional face-to-face services to digital platforms. Their work illustrates how external shocks accelerate institutional adaptation, reshaping public service delivery and influencing citizens' perceptions of accessibility and efficiency. Novianeli & Kurniasih (2025) examined the competence of civil servants in Banyumas and found that mismatches in skills and qualifications significantly affect service effectiveness. These studies highlight that institutional capacity and bureaucratic adaptation are central to understanding how healthcare services are experienced and interpreted by the public. In the context of Badung, where urban society demands efficiency and professionalism, the competence of healthcare staff becomes a critical factor in shaping patient perceptions.

Innovation in public service delivery also plays a critical role. Marselinus et al. (2024) investigated the adoption of the Jakarta Kini (JAKI) application and found that

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despite its relative advantages and compatibility, low adoption rates were driven by complexity and lack of trialability. Their findings demonstrate that technological innovations in public services must be accompanied by effective socialization and user engagement to shape positive perceptions. In the healthcare sector, similar dynamics occur when digital systems are introduced without adequate communication, leading to confusion and dissatisfaction among patients. This insight is particularly relevant for BPJS services in urban areas, where digitalization is increasingly used to streamline administrative processes but often fails to meet patient expectations due to lack of clarity and support.

Historical experiences of regional health insurance programs provide further insight. Widnyani (2015) analyzed the Bali Mandara Health Insurance (JKBM) and noted that while the program aimed to achieve good governance, its implementation was marred by bureaucratic inefficiencies, limited coverage, and perceptions of discrimination. This case illustrates how policy innovations, even when well-intentioned, can generate new layers of dissatisfaction if not aligned with public expectations and institutional capacity. The lessons from JKBM remain relevant for understanding BPJS services in Bali today, particularly in urbanized areas like Badung, where patients expect not only access but also fairness and quality in healthcare delivery.

Finally, the legal dimension of fairness in BPJS services must be acknowledged. Sigiro (2025) argued that despite regulatory frameworks emphasizing equity and accessibility, BPJS participants continue to face discriminatory treatment and procedural barriers in hospitals. Her analysis of distributive and procedural justice highlights the gap between normative principles and empirical realities. This reinforces the importance of examining not only patient satisfaction but also the social construction of fairness and justice in healthcare delivery. By situating the study within this legal framework, the analysis gains normative depth, linking empirical findings to constitutional and regulatory obligations.

In sum, this study seeks to demonstrate how urban society in Badung constructs its reality of BPJS healthcare services through experiences at RSUD Mangusada and Mengwi I Clinic. By employing Berger and Luckmann's framework as the primary analytical tool, complemented by public service and medical sociology, the research aims to reveal the interplay between institutional contexts, patient expectations, and social meanings. This approach provides both theoretical depth and practical relevance, offering insights into how healthcare services can be better aligned with the needs of an increasingly urbanized population. The originality of this study lies in its combination of comparative institutional analysis and social construction theory, ensuring that the findings contribute not only to academic debates but also to practical improvements in healthcare delivery.

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METHOD

This study employs a qualitative descriptive approach with a comparative design, chosen to capture personal experiences and social interpretations that cannot be measured quantitatively. The primary objective is to understand the perspectives and lived experiences of BPJS patients from diverse social backgrounds within the healthcare context. The comparative design is particularly relevant for examining differences across institutional settings and social groups, thereby highlighting how meanings are socially constructed in varied contexts.

Data collection was conducted through in-depth interviews, participatory observation, and documentation. In-depth interviews were carried out with BPJS patients at RSUD Mangusada and Mengwi I Clinic, focusing on their perceptions of service quality and the socio-cultural values embedded in healthcare interactions. The interview guide was structured around dimensions of service quality and relevant socio-cultural values, enabling thematic analysis of patients' social constructions of BPJS services. Participatory observation was undertaken directly at both institutions, where the researcher followed the flow of patient services, sat in waiting areas, observed interactions at registration counters, and noted communication between staff and patients.

This participatory element went beyond passive observation, as the researcher engaged with the environment by experiencing waiting times, observing staff responsiveness, and noting the atmosphere of service spaces. Such immersion allowed the researcher to capture relational dynamics and contextual meanings that might not be evident in interviews alone. As Dahlan et al. (2023) highlight, dimensions such as empathy and responsiveness are best understood through direct observation of patient–staff interactions, rather than solely through survey responses.

Documentation was also used as a secondary source of data, including brochures, information boards, BPJS standard operating procedures (SOP), the RSUD Mangusada Profile Book (2025), BPJS reports, and related scientific publications. These documents were examined to triangulate findings and to understand institutional structures, service pathways, and representations of BPJS participants. Sundoro (2023) notes that public perceptions of BPJS are strongly influenced by the information available and the manner in which it is communicated at healthcare facilities. Thus, documentation analysis provided insight into how institutional narratives shape patient expectations and experiences.

This approach ensured that observation went beyond surface-level behavior to include relational dynamics and contextual meanings. As Sadewo (2016) emphasizes, qualitative observation is not limited to recording actions but involves understanding the social context in which they occur. Documentation was also used as a secondary source of data, including brochures, information boards, BPJS standard operating procedures (SOP), the RSUD Mangusada Profile Book (2025), BPJS reports, and related scientific publications. These documents were examined to triangulate findings and to understand

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institutional structures, service pathways, and representations of BPJS participants. Sundoro (2023) notes that public perceptions of BPJS are strongly influenced by the information available and the manner in which it is communicated at healthcare facilities.

The study focuses on BPJS services at two different types of healthcare facilities: RSUD Mangusada, a secondary referral hospital at the regency level, and Mengwi I Clinic, a primary care facility at the sub-district level. RSUD Mangusada was selected because it serves as the main referral hospital in Badung, accommodating BPJS patients from diverse socio-economic backgrounds. Mengwi I Clinic was chosen to represent primary care services that are closer to the community and play a crucial role in preventive and promotive health. Dahlan et al. (2023) found that service aspects such as empathy and responsiveness significantly affect BPJS patient satisfaction, particularly at first-level facilities. The comparative design ensures that differences in institutional scale and complexity are systematically analyzed. Adinda & Achmadi (2025) emphasize that outpatient service quality and doctor–patient relationships are critical determinants of satisfaction, particularly in primary care settings, making the inclusion of clinic essential for capturing grassroots perspectives.

The study involved nine informants divided into three categories: BPJS service users, healthcare staff, and institutional managers. Informants were selected using snowball sampling, beginning with patient contacts at both institutions and expanding through recommendations from initial participants. While snowball sampling is effective in accessing hidden networks, it carries the risk of producing narratives aligned with institutional perspectives if initiated from official contacts. This limitation was consciously acknowledged, and efforts were made to balance perspectives by including informants from both RSUD Mangusada and Mengwi I Clinic. The total of nine informants is considered sufficient for qualitative inquiry, as depth of data is prioritized over breadth. To ensure adequacy, interviews were conducted until thematic saturation was reached, meaning no new insights emerged from additional participants. This approach aligns with Amirullah et al. (2021), who emphasized that patient satisfaction studies must ensure diversity of informants to capture variations in socio-economic background and service experiences.This approach ensured diversity of perspectives while acknowledging the potential limitation that starting from institutional contacts may produce narratives aligned with official viewpoints. Ramdhanni (2024) highlights that snowball sampling relies on social networks and informant referrals, while Abebe et al. (2025) emphasize that selecting informants based on social positions enriches understanding of healthcare realities. The informants included BPJS users aged 25–60, both male and female, who had accessed services at least twice at RSUD Mangusada or Mengwi I Clinic. Healthcare staff comprised doctors, nurses, and BPJS administrative officers directly involved in patient care. Institutional managers included heads of BPJS units and service managers responsible for policy and quality oversight. Karunia (2025)

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notes that urban society's perceptions of public services are universal yet often heterogeneous, making the inclusion of diverse informants essential.

Table 1. Informant Data

No	Informant Category	Jabatan/Peran	Institusi Asal	Kode Informan
1.	BPJS User	Outpatient/Inpatient	RSUD Mangusada	PL-01
2.	BPJS User	Outpatient/Inpatient	Community Mengwi I Clinic	PL-02
3.	BPJS User	Outpatient/Inpatient	RSUD Mangusada	PL-03
4.	Healthcare Staff	General Practitioner	Community Mengwi I Clinic	PK-01
5.	Healthcare Staff	Inpatient Nurse	RSUD Mangusada	PK-02
6.	Healthcare Staff	BPJS Administrative Staff	RSUD Mangusada	PK-03
7.	Institutional Manager	Head of BPJS Unit	RSUD Mangusada	PI-01
8.	Institutional Manager	Service Manager	Community Mengwi I Clinic	PI-02
9.	Institutional Manager	Head of Subdivision of Administration	RSUD Mangusada	PI-03

This distribution ensured balance between institutions, preventing RSUD Mangusada from dominating the narrative. The inclusion of both patients and staff allowed triangulation of perspectives, while managers provided insight into institutional policies.

Data analysis followed the interactive model of Miles and Huberman, consisting of three stages: data reduction, data display, and conclusion drawing. Data reduction involved organizing and simplifying interview narratives and observation notes according to research relevance. Data display was conducted through thematic narratives and meaning matrices to identify socio-cultural patterns emerging from patient experiences. This approach is considered effective in qualitative research for enabling comprehensive and systematic exploration of phenomena (Miles & Huberman in Sadewo & Legowo, 2016).

Additionally, thematic categorization was applied based on Berger and Luckmann's social construction theory. Themes such as politeness, presence of medical staff, and comfort of treatment spaces were mapped to the stages of externalization, objectivation, and internalization. For example, patients' expressions of politeness represent externalization of expectations, institutional routines and service structures reflect objectivation, and patients' acceptance or rejection of service experiences indicate internalization. This mapping ensures that differences in perceptions are analyzed as

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products of meaning construction rather than merely variations in service quality. By explicitly linking themes to theoretical stages, the analysis demonstrates how patient narratives evolve into shared social realities.

To ensure validity, triangulation of sources was employed by comparing interview data, observations, and institutional documents. This process involved cross-checking themes across different sources to strengthen the credibility of findings and broaden understanding of the studied phenomena. EF et al. (2025) emphasize that triangulation ensures that captured meanings reflect patients' social experiences rather than researchers' subjective interpretations. Khotimah et al. (2025) further highlight the significance of triangulation in producing reliable and relevant qualitative analyses. In addition, reflexivity was maintained throughout the research process, with the researcher critically reflecting on positionality and potential biases introduced by institutional access. This reflexive stance ensured that findings were not merely descriptive but analytically grounded in the social construction of meaning.

RESULTS AND DISCUSSION

The narratives of urban society regarding BPJS services at RSUD Mangusada reveal a clear tension between expectations and lived experiences. Patients frequently described irregularities in the queue system, such as skipped numbers without explanation, which generated anxiety and distrust. Rather than presenting this as a technical failure of the hospital, it is more accurate to interpret it as patient perceptions of disorder that conflict with their expectations of structured service. In interviews, patients used phrases such as *"tidak jelas"* (unclear) and *"melompat nomor"* (skipped numbers), which were repeated among waiting patients and became collective stories that reinforced dissatisfaction. These perceptions resonate with Gusnita et al. (2023), who emphasize that inefficiencies in administrative systems directly shape negative public evaluations of service quality.

In contrast, narratives about BPJS services at Mengwi I Clinic were more positive and constructive. Patients highlighted orderly queues and proactive explanations from administrative staff, which provided reassurance and reduced confusion. Observations confirmed that staff frequently approached patients in waiting areas to clarify procedures, a practice that patients described as *"membantu sekali"* (very helpful). These interpersonal interactions illustrate how communication becomes externalized expectations, objectivized through institutional routines, and internalized as trust in the facility. This finding aligns with Pernando et al. (2025), who underscore the vital role of interpersonal communication in shaping patient satisfaction.

The attitudes of healthcare workers emerged as a critical factor in constructing the image of BPJS services (Masereka et al., 2025). At Mengwi I Clinic, staff demonstrated empathy and prioritized patients with urgent conditions, fostering two-way communication that made patients feel respected and heard. In interviews, patients

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recalled specific phrases such as *"dokternya mendengarkan keluhan saya"* (the doctor listened to my complaint), which became part of a collective narrative of care. Conversely, at RSUD Mangusada, patients reported less communicative interactions and limited educational support. While RSUD's mission statement emphasizes professionalism and international standards, these ideals were not consistently reflected in patient experiences. Thus, it is more precise to frame these as patient perceptions rather than institutional failures. Himelda et al. (2019) further confirm that empathy and responsiveness are key elements in shaping BPJS patient satisfaction, reinforcing the importance of relational dynamics in constructing institutional meaning.

Efficiency in medication retrieval was another crucial issue. At RSUD Mangusada, patients reported waiting two to three hours for prescriptions, describing the process as *"melelahkan"* (exhausting) and *"menghambat pemulihan"* (hindering recovery). Observations confirmed long queues at the pharmacy, with patients sharing complaints among themselves, which reinforced a collective narrative of inefficiency. At Mengwi I Clinic, medication retrieval was faster and more coordinated, shaping perceptions of efficiency and care. These findings are consistent with Ningtyas et al. (2024), who identify time effectiveness as a key determinant of BPJS patient satisfaction, and Wulansari et al. (2024), who note that systemic payment structures often constrain healthcare delivery.

Transparency and accountability also shaped social constructions of service. At RSUD Mangusada, patients perceived complaint mechanisms as ineffective, with suggestion boxes rarely addressed. This perception echoes Sukardi et al. (2024), who argue that unresponsive complaint management reduces public satisfaction. At Mengwi I Public Health Center, open dialogue between patients and staff allowed grievances to be addressed directly, reinforcing trust. Observations recorded patients discussing their complaints openly with staff, which were then resolved in real time, illustrating how collective experiences become objectivized as institutional responsiveness.

Accessibility emerged as a factor in shaping institutional meaning. Patients described clinic as geographically close and procedurally simple, making it inclusive and approachable for lower-income groups. RSUD Mangusada, by contrast, was perceived as distant and bureaucratically complex, often described as *"rumit"* (complicated) and *"menakutkan"* (intimidating). These perceptions were not merely individual evaluations but collective narratives that circulated among patients, forming stigmas and influencing choices of healthcare facilities. This dynamic illustrates Berger and Luckmann's (1966) notion that institutional meanings are socially constructed through repeated interactions and shared stories.

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Table 2. Factors Shaping Perceptions and Institutional Meanings

Factors Shaping Perceptions	Community Health Center (Small Institution)	Hospital (Large Institution)
Staff Interaction	Friendly, communicative	Formal, hurried
Accessibility	Easy to reach, simple procedures	Distant, complex procedures
Waiting Time	Short, efficient	Long, uncertain
Facilities	Simple but functional	Advanced but not always fulfilling expectations
Institutional Meaning	Familiar, local, inclusive	Formal, distant, expectation-driven

The distinction between small and large institutions was evident in patient expectations. Clinic was perceived as a familiar, flexible, and locally oriented space, while RSUD Mangusada was viewed as formal, distant, and burdened with high expectations. Beyond satisfaction indicators, these differences represent how patient stories and shared experiences construct collective opinions. For example, when one patient described RSUD as *"berjarak"* (distant), others echoed the phrase, transforming individual dissatisfaction into a collective stigma.

Local Balinese culture also influenced how services were interpreted. Patients valued politeness, harmony, and respect for authority, and interviews revealed appreciation when staff used local greetings or demonstrated empathy consistent with cultural norms. Observations recorded staff addressing patients with respectful language, which patients described as *"sesuai adat"* (in line with tradition). These cultural elements illustrate how externalized expectations are objectivized through staff behavior and internalized as trust. Hasrillah et al. (2021) confirm that culturally contextualized services are more effective in building public trust.

Figure 1. The registration counter at Mengwi I Public Health Center, illustrating the proximity of primary health services to the local community

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Trust in institutions was shaped by consistency of experiences. At RSUD Mangusada, inconsistent service eroded trust, while integrated and transparent practices strengthened patient loyalty. Sholechan et al. (2019) highlight that social security participation increases when institutions demonstrate accountability and efficiency. In this study, trust was not derived from formal information alone but from repeated, socially shared experiences.

The implications of these findings extend beyond service evaluation to the construction of social reality. Queue irregularities and communication gaps at RSUD Mangusada represent objectivized routines that patients interpret negatively, while efficient and empathetic practices at Mengwi I Clinic are internalized as trust and inclusivity. Widjaja et al. (2023) emphasize that high expectations of BPJS services must be aligned with evolving social perceptions. Similarly, Muslim et al. (2025) show that culturally grounded approaches enhance healthcare effectiveness, suggesting that RSUD Mangusada could integrate local values into staff training.

Collective narratives also influence institutional reputation. Negative experiences at RSUD Mangusada spread among patients, forming stigmas that deter future visits, while positive stories at Mengwi I Clinic enhance its image and encourage participation. Ritonga et al. (2024) confirm that outpatient service quality strongly shapes patient satisfaction and recommendations. Thus, patient stories function as externalizations that, once shared, become objectivized realities influencing collective decision-making.

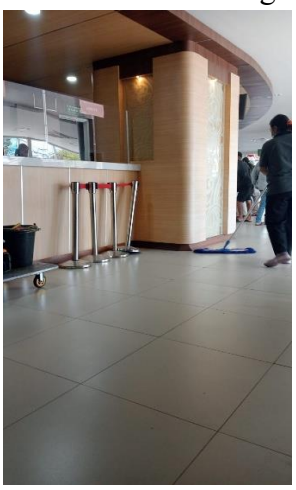

Figure 2. The registration counters and queues at RSUD Mangusada, serving as the primary touchpoint for patient interaction with public services

In theoretical terms, this study demonstrates that BPJS service realities are socially constructed through the dialectical processes of externalization, objectivation, and internalization. Patient expectations are externalized in narratives of politeness, efficiency, and accessibility; institutional routines such as queues, communication, and complaint mechanisms are objectivized as shared realities; and these experiences are internalized as trust, stigma, or loyalty. The comparative analysis of RSUD Mangusada

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and Mengwi I Clinic reveals that differences in institutional scale and responsiveness produce distinct social realities. Ultimately, BPJS services are not merely evaluated as fast or slow, but are constructed as meaningful realities shaped by collective experiences, cultural values, and institutional practices.

Tabel 3. Pratical Implication Based on Field Findings

Field Findings	Practical Implications	Strategic Goals
Digital queues often malfunction	Improve digital queue system	Increase efficiency and service certainty
Staff communication lacks empathy	Empathy-based communication training rooted in local culture	Enhance patient comfort and trust
Patient information unsynchronized across units	Integrate information systems between clinics and pharmacies	Accelerate service flow and medication retrieval
Lack of patient knowledge about BPJS procedures	Regular socialization of BPJS rights and obligations	Improve literacy and public satisfaction

Patients' accounts of long queues and administrative delays at RSUD Mangusada were not merely individual complaints but became collective narratives that circulated among communities, shaping expectations of BPJS services. For instance, one informant described waiting "almost two hours" while observing others express frustration; such stories were later retold in family and neighborhood discussions, reinforcing a shared stigma that BPJS patients must endure longer waits. This illustrates Berger and Luckmann's concept of objectivation, where repeated narratives crystallize into a social fact perceived as "normal" for BPJS care. Similar findings were reported in Pekanbaru Medical Center Hospital, where administrative bottlenecks and inactive membership status created perceptions of discrimination, later spreading through online reviews and community discourse.

Cultural norms in Bali further shaped these perceptions. Patients often emphasized politeness and respect as markers of quality service. Observations revealed that staff greetings, use of honorifics, and non-verbal cues (smiles, gestures) were interpreted as signs of empathy. When these were absent, patients described feeling "ignored" or "less valued," which became part of collective meaning-making. This aligns with Astawastini et al.'s study at Mangusada Hospital, which found that risk communication and caring behavior significantly influenced satisfaction, with caring behavior increasing satisfaction nearly tenfold. Thus, politeness was not simply etiquette but a socially constructed indicator of fairness and justice in healthcare.

Strong claims about "international standards" or "paripurna accreditation" must be carefully framed. While RSUD Mangusada indeed publicized its accreditation status, patient interviews revealed that many interpreted these labels as symbolic rather than experiential. For example, one informant stated, "They say it is paripurna, but what I feel

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is still waiting too long." This demonstrates how institutional discourse (objectivation) may diverge from patient internalization, producing skepticism. Yandi et al. highlight similar tensions in their legal analysis of BPJS services, where formal justice principles are codified but operational practices often fail to deliver equitable experiences.

The implications for theory are clear: queues, communication breakdowns, and waiting times are not only operational issues but socially constructed realities. Patients externalize dissatisfaction through stories, institutions objectivate these experiences into routine practices, and communities internalize them as expectations. Over time, these processes generate collective perceptions that influence hospital choice, loyalty, and trust. Siagian et al. found that hospital image and cleanliness significantly shaped referral decisions among hemodialysis patients in Medan, reinforcing the idea that perceptions become decisive social facts.

Patients frequently described prolonged waiting times as a defining feature of BPJS services. One informant recounted: *"I waited almost two hours before seeing the doctor, and others around me were complaining too."* Such accounts were not isolated; they were retold in family conversations and community discussions, forming a collective expectation that BPJS patients must endure longer waits. Observations confirmed that queues were visibly longer for BPJS counters compared to general patients, reinforcing perceptions of inequality. This aligns with Renata et al. (2025), who found that BPJS outpatient waiting times at FMC Bogor Hospital averaged 45 minutes, exceeding the national standard of 30 minutes.

Communication emerged as another critical factor. Patients valued politeness, empathy, and clear explanations. When staff greeted patients with honorifics or offered supportive gestures, satisfaction increased. Conversely, when communication was rushed or dismissive, patients felt neglected. Observations revealed that non-verbal cues—such as smiles or attentive listening—were interpreted as signs of respect. Astawastini et al. (2024) demonstrated that risk communication and caring behavior significantly influenced satisfaction, with caring behavior increasing satisfaction nearly tenfold.

Balinese cultural norms of politeness and communal solidarity shaped patient interpretations of service quality. Informants often equated respectful greetings and attentive listening with fairness and justice. When these cultural expectations were unmet, dissatisfaction was amplified. This reflects Berger and Luckmann's concept of externalization, where cultural values are projected into healthcare interactions, later objectivated as institutional routines, and internalized as collective perceptions.

RSUD Mangusada promoted its *"paripurna accreditation"* and *"international standards."* However, patients often interpreted these claims skeptically. One informant remarked: *"They say it is paripurna, but I still wait too long."* This illustrates a divergence between institutional discourse and patient internalization. Yandi et al. (2026) similarly found that while BPJS regulations codify justice, operational practices often fail to deliver equitable experiences.

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The findings demonstrate that queues, communication, and waiting times are not merely technical issues but socially constructed realities. Patients externalize dissatisfaction through narratives, institutions objectivate these experiences into routine practices, and communities internalize them as expectations. Over time, these processes generate collective perceptions that influence hospital choice, loyalty, and trust.

For example, stories of long queues became stigmatized narratives: *"BPJS patients always wait longer."* These stories circulated in neighborhoods, shaping collective expectations. This mirrors Siagian et al. (2025), who found that hospital image and cleanliness significantly influenced referral decisions among hemodialysis patients in Medan.

Politeness and empathy were objectivated as indicators of fairness. Patients interpreted respectful greetings as evidence of justice, while dismissive communication was seen as discrimination. Astawastini et al. (2024) confirmed that caring behavior increased satisfaction ninefold, reinforcing the role of communication in constructing social reality.

Pharmaceutical delays were narrated as systemic failures. Patients described limited drug availability as *"BPJS patients get fewer medicines."* These narratives spread collectively, forming stigmas. Arief et al. (2024) highlighted that responsiveness in pharmaceutical services strongly correlated with satisfaction, showing how operational issues became social facts.

Legal perspectives emphasized justice (al-'adl) as a normative principle. Yandi et al. (2026) found that dual payment systems and inconsistent tariff rules hindered fairness, creating perceptions of discrimination. Patients at RSUD Mangusada echoed similar concerns, interpreting longer waits and limited access as unfair treatment. Thus, justice was socially constructed through patient experiences rather than institutional claims.

Accountability emerged as a critical dimension. Lusiana & Ine (2024) found that BPJS services at Ciamis Hospital suffered from weak accountability, leading to distrust. At RSUD Mangusada, patients similarly questioned institutional claims, emphasizing that trust was built through everyday interactions rather than accreditation labels.

Comparative studies highlight differences between public and private hospitals. Zamil & Areiqat (2025) found that private hospitals scored higher in responsiveness and communication, while public hospitals were valued for affordability but criticized for waiting times. This mirrors Mangusada patients' experiences, where affordability was appreciated but long queues undermined satisfaction.

Ilham et al. (2025) showed that administrative bottlenecks at Pekanbaru Medical Center created dissatisfaction, particularly inactive membership and long queues. Similar issues were observed at Mangusada, where administrative delays reinforced perceptions of inequality.

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Rais et al. (2024) found that 30.7% of BPJS patients at Lasinrang Hospital rated admission procedures poorly, citing complicated registration and unfriendly staff. These findings resonate with Mangusada patients, who described admission as bureaucratic and slow, reinforcing stigmas of inefficiency.

CONCLUSION

This study confirms that the perceptions of urban society toward BPJS healthcare services at RSUD Mangusada and Mengwi I Clinic are constructed through direct experiences, social interactions, and the influence of local cultural norms. The differences in service quality between the two institutions demonstrate that healthcare worker attitudes, procedural orderliness, accessibility, and transparency of information are decisive factors in shaping public trust. At RSUD Mangusada, bureaucratic complexity and prolonged waiting times generate collective narratives of inefficiency, while at Mengwi I Clinic, proximity and procedural efficiency foster perceptions of inclusivity and responsiveness. These findings highlight that the social meaning of healthcare institutions is dynamic, shaped not only by technical structures but also by shared stories and cultural expectations.

Theoretically, the results show that BPJS service realities are formed through the dialectical processes of externalization, objectivation, and internalization as proposed by Berger and Luckmann. Patient expectations are externalized in narratives of politeness, efficiency, and accessibility; institutional routines such as queues, communication, and complaint mechanisms are objectivized as shared realities; and these experiences are internalized as trust, stigma, or loyalty. Thus, the reality of BPJS services is not simply "RSUD slow, Puskesmas fast," but rather a socially constructed meaning that emerges from collective experiences and cultural values within urban society.

Practical implications can be distinguished at three levels. For RSUD Mangusada, priority should be given to improving the digital queue system, integrating information between clinics and pharmacies, and strengthening empathetic communication training that incorporates local cultural values. For Mengwi I Clinic, sustaining proactive communication and maintaining efficiency in medication retrieval are essential to preserve trust and inclusivity. At the broader BPJS policy level, regular socialization of participant rights and obligations through visual media and community forums is necessary to enhance literacy and align expectations with institutional realities.

Future research is recommended in other urban contexts using interdisciplinary approaches to provide a more comprehensive understanding of how healthcare service realities are socially constructed. By situating BPJS services within the framework of social construction, this study emphasizes that healthcare delivery is not merely an administrative process but a social phenomenon requiring consistency, transparency, and cultural sensitivity to meet the needs of an increasingly urbanized population.

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