

DRIVERS OF PATIENTS' CHOICE OF HOSPITAL IN JAKARTA, INDONESIA

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ABSTRACT: This study examines the factors shaping patients' hospital choices in Jakarta. It contributes to healthcare choice research by clarifying how financial access, service attributes, institutional characteristics, and operational efficiency jointly influence hospital selection in a major urban healthcare market. Data were collected from 430 patients through an online questionnaire and analyzed using PLS-SEM with SmartPLS. The findings show that insurance options, service quality, hospital facilities, hospital type, and waiting time significantly influence hospital choice, whereas treatment cost does not. Insurance accessibility emerges as the most influential consideration, followed by service quality. The findings indicate that patients evaluate hospitals beyond direct treatment expenses and place greater emphasis on accessibility, service experience, institutional characteristics, and operational convenience. Hospital managers should therefore strengthen insurance accessibility, service quality, facility provision, and waiting-time management to improve patient preference and healthcare access.

Keywords: Hospital Choice; Insurance Accessibility; Service Quality; Healthcare Access; Patient Preference

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INTRODUCTION

Hospital choice represents an important healthcare decision because the selected provider can shape patients' access to appropriate treatment, service experience, continuity of care, and ultimately their health outcomes (Teymourifar et al., 2025). Unlike ordinary consumption decisions, choosing a hospital involves considerable uncertainty, information asymmetry, perceived risk, and financial consequences. Patients must evaluate not only the expected quality of medical treatment but also whether the hospital is financially accessible, adequately equipped, operationally efficient, and capable of providing a satisfactory care experience. Hospital choice therefore reflects a multidimensional decision in which clinical, economic, institutional, and service-related considerations intersect. Understanding this decision is important not only for individual patients but also for healthcare providers seeking to allocate resources effectively and health systems attempting to improve equitable access to care.

This issue becomes particularly important in Jakarta. As a densely populated metropolitan area, Jakarta contains a heterogeneous healthcare market in which public and private hospitals differ substantially in service capacity, facilities, financing arrangements, waiting times, and patient experience. Patients may have numerous hospital alternatives, yet greater choice does not necessarily translate into easier decision making or more equitable healthcare access. Differences in income, insurance coverage, geographic accessibility, information availability, and service expectations can constrain the options available to particular patient groups. Hospital selection in this setting therefore extends beyond simple preference. It reflects how patients balance desirable medical services against financial and operational constraints.

Existing evidence indicates that patients consider several attributes when choosing healthcare providers. Affordability, hospital reputation, availability of medical professionals, and healthcare facilities can influence the attractiveness of a hospital (Chauhan et al., 2021). Service quality has also become increasingly salient as patients become more informed and expect healthcare providers to deliver responsive, reliable, and patient-centered services. Patients do not experience a hospital solely through clinical treatment. Registration procedures, employee responsiveness, physical facilities, waiting periods, payment mechanisms, and interactions with healthcare professionals collectively shape their assessment of the institution. Consequently, hospitals compete not only throu

THEORETICAL OVERVIEW

Hospital choice can be understood as a multidimensional decision in which patients evaluate whether a healthcare provider can satisfy their medical needs within their financial, institutional, and service constraints. Unlike ordinary service selection, hospital choice involves uncertainty, perceived health risk, information asymmetry, and potentially substantial financial consequences. Patients therefore assess several hospital attributes simultaneously rather than relying on a single consideration. Financial accessibility, physical and technological facilities, service quality, waiting time, hospital ownership, and treatment costs may collectively determine whether a hospital is considered acceptable and preferable. These attributes also operate within the personal circumstances of patients because demographic characteristics and payment arrangements can alter the relative importance attached to each hospital attribute.

Insurance options represent an important component of this decision because health insurance determines the extent to which patients can access healthcare without bearing the full financial burden of treatment. Insurance choice refers to the form of health coverage available to patients and the conditions under which that coverage can be used. Patients may consider the breadth of hospital networks, treatment coverage, administrative requirements, claim procedures, reimbursement certainty, and the availability of cashless services when evaluating hospitals. Insurance therefore functions not simply as a payment mechanism but also as an access mechanism that determines which healthcare providers are realistically available to patients. Health insurance can reduce financial barriers and broaden patients' access to healthcare facilities that might otherwise be unaffordable (Andoh-Adjei et al., 2019; Cheng et al., 2025).

Coverage quality, ease of claims, and transparency in insurance procedures can also strengthen confidence in the healthcare transaction and reduce uncertainty regarding future expenditures (Li et al., 2025; Sobhani Shahri et al., 2025). A hospital that accommodates patients' insurance arrangements can therefore become more attractive because it reduces both perceived financial risk and administrative burden. Insurance accessibility may consequently influence hospital choice more strongly than nominal treatment prices when patients focus on the actual out-of-pocket consequences of receiving care.

H1: Insurance options have a positive effect on patients' decision to choose a hospital.

Hospital facilities constitute another important signal through which patients evaluate the capability of healthcare providers. Hospital facilities encompass the physical and technological infrastructure supporting diagnosis, treatment, monitoring, comfort, and the overall delivery of medical services. Patients may evaluate the availability of modern medical equipment, diagnostic technology, inpatient rooms, emergency facilities, pharmacies, laboratories, digital systems, supporting amenities, cleanliness, accessibility, and the general condition of hospital infrastructure. Such facilities are particularly important because patients often possess limited technical knowledge to evaluate clinical competence directly. Observable physical and technological characteristics can therefore serve as tangible indicators of institutional capacity. Hospital facilities, including medical equipment, physical comfort, and supporting amenities, have been associated with perceived service quality and patient preferences (Stefanovska, 2014; Michael et al., 2019). Advanced equipment can signal diagnostic and therapeutic capability, while clean, comfortable, and well-organized facilities can reduce anxiety and strengthen confidence in the provider. Digital infrastructure can further simplify registration, payment, medical records, and communication. Patients may therefore interpret strong hospital facilities as evidence that an institution possesses the resources required to deliver effective and reliable care.

H2: Hospital facilities have a positive effect on patients' decision to choose a hospital.

Service quality represents the experiential dimension of hospital choice. It reflects patients' evaluations of how healthcare is delivered and commonly encompasses reliability, responsiveness, assurance, empathy, and tangible evidence of professional service. While hospital facilities demonstrate what an institution possesses, service quality reflects how effectively those resources are transformed into patient care. Interactions with physicians, nurses, administrative personnel, pharmacists, and other employees shape patients' evaluations throughout the healthcare journey. Clinical competence remains essential, but patients also assess whether employees provide clear information, respond promptly, demonstrate empathy, protect patient safety, and treat individuals with respect. Service quality therefore reduces uncertainty by providing patients with evidence that the hospital can deliver care consistently and responsibly. Positive interactions with medical personnel, empathetic treatment, responsiveness, and patient-safety practices contribute to patient satisfaction and loyalty (Wu et al., 2025; Iqbal et al., 2025). These experiences can influence hospital choice because patients are more likely to prefer healthcare institutions in which they expect reliable treatment and respectful interpersonal interaction. Service quality may also generate positive recommendations and reinforce hospital reputation, extending its influence beyond patients' direct experiences.

H3: Service quality has a positive effect on patients' decision to choose a hospital.

Waiting time introduces an operational dimension into hospital selection. It refers to the period between patients entering the service process and receiving the required medical consultation, diagnostic procedure, treatment, or other healthcare service. Waiting time is important because patients evaluate healthcare not only according to treatment outcomes but also according to the effort, inconvenience, and uncertainty involved in obtaining treatment. Excessive waiting can create psychological discomfort, opportunity costs, dissatisfaction, and perceptions of poor organizational capacity. Patients with employment obligations, caregiving responsibilities, mobility limitations, or urgent healthcare needs may be particularly sensitive to delays. Waiting time therefore functions as a visible indicator of operational efficiency. Efficient patient flow may signal that the hospital possesses adequate staffing, scheduling, coordination, and administrative capability. Conversely, prolonged or unpredictable delays can weaken perceptions of service reliability. Waiting experiences and uncertainty during the service process

influence patients' evaluations of healthcare efficiency and satisfaction (Elgeka et al., 2025; Xia et al., 2025). Patients may consequently prefer hospitals capable of providing timely access to medical services and predictable service processes. In this sense, favorable waiting-time management can become an important source of patient preference, particularly in urban healthcare markets where alternative providers are available.

H4: Waiting time has a positive effect on patients' decision to choose a hospital.

Hospital type can further influence patient choice because ownership and institutional status provide informational cues regarding service orientation, affordability, accessibility, and expected care experience. Hospital type generally distinguishes between public and private healthcare institutions, although substantial heterogeneity may exist within each category. Public hospitals are commonly associated with broader social mandates, government support, subsidized services, and extensive participation in national health insurance schemes. Private hospitals may be perceived as providing greater convenience, shorter administrative processes, greater physical comfort, or more personalized services, although such benefits may be accompanied by higher costs. Patients therefore do not necessarily evaluate hospital ownership independently from other attributes. Instead, institutional type can create expectations about pricing, insurance acceptance, waiting time, facilities, and service quality before patients directly experience the hospital. Patients may consequently compare private hospitals, which can be associated with speed and convenience, with public hospitals, which may be associated with affordability and broader subsidized access (Teymourifar et al., 2025; Tresnanti & Sulistiadi, 2024). The preferred institutional type can depend on the patient's medical needs, financial circumstances, insurance status, and expectations regarding the healthcare experience. Hospital type thus serves as an institutional signal that can influence which provider patients consider suitable.

H5: Hospital type has a positive effect on patients' decision to choose a hospital.

Treatment cost represents the direct economic burden associated with obtaining healthcare and remains an important consideration because medical expenditures can compete with other household needs. Treatment costs can include consultation fees, diagnostic procedures, medication, hospitalization, surgery, rehabilitation, and other direct expenditures. Patients can also experience indirect costs through transportation, lost working time, caregiving requirements, and repeated hospital visits. The significance of cost is therefore broader than the listed price of medical treatment. Patients assess whether expected expenditures are compatible with their available financial resources, insurance protection, and perceived value of the services received. Treatment costs and tariff transparency can influence healthcare decisions because patients require sufficient information to anticipate the financial consequences of treatment (Goudarzi et al., 2025; Donovan et al., 2025). Hospitals providing transparent pricing and flexible payment arrangements can reduce uncertainty and make healthcare expenditures easier to manage. However, treatment cost may not operate independently from insurance because insured patients can be less sensitive to nominal prices when a substantial proportion of expenditure is covered. Hospital choice therefore reflects not simply whether treatment is inexpensive but whether the financial burden is predictable, manageable, and proportionate to the expected quality of care.

H6: Treatment costs have a positive effect on patients' decision to choose a hospital.

The influence of hospital attributes must also be understood within the demographic and financial circumstances of patients. Demographic characteristics such as age, gender, education, residential location, and socioeconomic status can shape healthcare needs, information-processing abilities, mobility, financial constraints, and expectations regarding medical services. Older patients or patients with chronic illnesses may attach greater importance to specialist availability and continuity of care, whereas younger or more technologically familiar patients may value digital access and administrative convenience. Geographic location can increase sensitivity to transportation and accessibility, while socioeconomic status can alter patients' willingness or ability to consider higher-cost providers. Payment type can create a similar contextual effect. Patients paying directly, using Indonesia's national health insurance program, or relying on private

insurance may face different hospital networks, reimbursement arrangements, administrative requirements, and levels of financial exposure.

These contextual differences imply that patients do not necessarily evaluate identical hospital attributes in identical ways. A characteristic that strongly influences one patient group may have less relevance for another because the constraints surrounding healthcare access differ. Sociodemographic characteristics and payment arrangements have been associated with differences in how patients evaluate healthcare providers and hospital attributes (Wu et al., 2025; Tilahun et al., 2025). Demographic characteristics and payment type can therefore help explain heterogeneity in hospital choice beyond the direct influence of hospital-level attributes. Incorporating these characteristics provides a broader explanation of hospital selection because it recognizes that healthcare decisions emerge from interactions between provider characteristics and the circumstances under which patients seek treatment.

H7: Patient demographic characteristics and payment type are predicted to have a relationship with patients' decision to choose a hospital.

RESEARCH METHODS

This study employed a quantitative cross-sectional design to examine the factors influencing patients' hospital choice in Jakarta, Indonesia. The unit of analysis was the individual patient, and the target population comprised patients who had experience obtaining healthcare services from public or private hospitals in the Jakarta area. The empirical model examined hospital choice as the focal endogenous construct and incorporated insurance options, hospital facilities, service quality, waiting time, hospital type, and treatment cost as its principal explanatory factors. Patient demographic characteristics and payment type were also considered to capture differences in healthcare choice across patient groups.

Primary data were collected through a structured online questionnaire administered using Google Forms. The survey yielded 430 usable responses, which constituted the final analytical sample. Participation was based on respondents' experience with hospital services in Jakarta, ensuring that evaluations of hospital attributes were grounded in actual healthcare encounters rather than hypothetical preferences. The questionnaire was designed to capture respondents' perceptions of the constructs specified in the conceptual model. Responses were recorded electronically, transferred automatically to Google Spreadsheets, screened for analytical suitability, and subsequently exported in comma-separated values (CSV) format for statistical analysis. Secondary information obtained from government publications, institutional reports, and academic literature was used exclusively to establish the contextual background, define the research constructs, and support the development of the theoretical framework; it was not included as empirical input in the structural model.

Sample adequacy was assessed with reference to the structural complexity of the PLS-SEM model rather than by multiplying the number of constructs and measurement indicators. Under the traditional 10-times rule, the minimum sample is determined by the largest number of structural paths directed toward a single endogenous construct. Because hospital choice receives paths from the principal explanatory constructs, the final sample of 430 respondents substantially exceeds this conventional minimum requirement. The achieved sample also provides a considerably stronger basis for estimating a model containing multiple simultaneous relationships than the minimum threshold implied by the heuristic rule. Accordingly, the final sample was considered adequate for estimating the proposed PLS-SEM model.

Data analysis was conducted using Partial Least Squares Structural Equation Modeling (PLS-SEM) in SmartPLS. PLS-SEM was selected because the study seeks to estimate multiple relationships among latent constructs simultaneously and to explain variation in patients' hospital-choice decisions. The analysis followed two sequential stages. First, the measurement model was assessed to establish the reliability and validity of the constructs. Indicator reliability was evaluated through outer loadings, while internal consistency reliability was examined using Cronbach's alpha, rho_A, and composite reliability. Convergent validity was assessed using the average variance extracted (AVE). Discriminant validity was evaluated using the Fornell-Larcker criterion and the heterotrait-monotrait ratio of correlations (HTMT). Collinearity was examined through variance inflation factors to ensure that the estimated structural relationships were not distorted by excessive predictor overlap.

Second, the structural model was evaluated after satisfactory measurement quality had been established. The analysis examined the direction, magnitude, and statistical significance of the hypothesized relationships between insurance options, hospital facilities, service quality, waiting time, hospital type, treatment cost, and hospital choice. Statistical inference was conducted using bootstrapping with 5,000 resamples. Model explanatory capability was assessed using the coefficient of determination (R^2), while effect sizes (f^2) were examined to determine the relative contribution of individual predictors. Predictive relevance was evaluated using Q^2 where applicable. Model-level diagnostics, including the standardized root mean square residual (SRMR), were also considered as supplementary indicators of model adequacy. These procedures provide a transparent and replicable analytical sequence from measurement validation to structural hypothesis testing.

RESULTS

The respondent profile provides important context for interpreting hospital-choice behavior because healthcare preferences may differ according to patients' demographic characteristics and life stages. Gender and age are particularly relevant because they can shape healthcare needs, familiarity with hospital services, perceptions of risk, and sensitivity to service convenience. Examining the composition of the sample therefore establishes whether the empirical results reflect a relatively balanced patient population or are concentrated within particular demographic groups. Table 1 presents the demographic distribution of the respondents included in the final analysis.

Table 1. Distribution of Respondents

Category	Sub-Category	Amount (n)	Percentage (%)
Gender	Male	217	50,46%
	Female	213	49,54%
Total		430	100%
Age	18–30 years	180	41,86%
	31–40 years	120	27,90%
	41–50 years	68	15,81%
	51–60 years	54	12,56%
	>60 years	8	1,87%
Total		430	100%

Source: Authors Compilation (2025)

The demographic distribution indicates a nearly balanced representation of male and female respondents, reducing the likelihood that the overall findings are dominated by one gender group. The age profile is more concentrated among younger adults, although respondents from middle-aged and older categories are also represented. This composition is relevant because younger patients may differ from older patients in their expectations regarding service speed, digital accessibility, insurance convenience, and hospital facilities. The broader age coverage nonetheless provides sufficient variation to examine hospital choice across different patient profiles.

Table 2. Construct Validity and Reliability - Cronbach's Alpha

Constructs	Cronbach's alpha	CR (rho_c)	AVE
Treatment Cost	0,839	0,881	0,533
Hospital Facilities	0,775	0,855	0,596
Hospital Type	0,809	0,875	0,637
Patient Decision in Choosing a Hospital	0,856	0,903	0,699
Service Quality	0,839	0,880	0,551
Insurance Options	0,814	0,878	0,642
Waiting Time	0,886	0,911	0,595

Source: Adapted Smartpls 4 Output (2025)

Before testing the structural relationships, the adequacy of the measurement model was examined to establish whether the latent constructs were measured consistently. Internal consistency is fundamental in PLS-SEM because structural coefficients are meaningful only when the indicators belonging to a construct capture the underlying concept with sufficient reliability. Cronbach's alpha and composite reliability were therefore examined jointly. Using both measures provides a more complete assessment because Cronbach's alpha applies a more restrictive assumption of equal indicator reliability, whereas composite reliability incorporates differences in indicator contributions. Table 2 reports the internal consistency assessment for all study constructs.

The results provide consistent evidence that the constructs demonstrate satisfactory internal consistency. Both reliability criteria remain above the specified minimum standard across treatment cost, hospital facilities, hospital type, hospital choice, service quality, insurance options, and waiting time. The consistency between Cronbach's alpha and composite reliability further indicates that the measurement quality is not dependent on a single reliability criterion. These findings support the stability of the indicators within their respective constructs and provide an adequate basis for proceeding to validity assessment. Importantly, these results establish reliability rather than construct validity itself; convergent and discriminant validity require separate evaluation.

Following the assessment of internal consistency, convergent validity was examined to determine whether indicators assigned to the same construct share sufficient common variance. This stage is important because a construct should explain a substantial proportion of the variance in its indicators before relationships between latent variables are interpreted. Average variance extracted provides a direct assessment of this requirement by comparing variance captured by the construct with variance attributable to measurement error. Table 3 therefore evaluates whether the measurement items converge sufficiently on the theoretical concepts they are intended to represent.

Table 3. Discriminant Validity – HTMT

Construct	TC	HF	HT	HC	SQ	IO	WT
TC	—						
HF	0.861	—					
HT	0.844	0.935	—				
HC	0.978	0.886	0.906	—			
SQ	0.050	0.079	0.060	0.050	—		
IO	0.938	0.965	0.994	0.984	0.041	—	
WT	0.716	0.971	0.768	0.705	0.060	0.807	—

Source: Data Analysis Results with Smart PLS 4 (2025)

The results support convergent validity across all constructs because each construct captures more indicator variance than the minimum criterion required for acceptable convergence. Hospital choice, insurance options, and hospital type demonstrate particularly clear convergence, while treatment cost and service quality satisfy the criterion with comparatively narrower margins. The pattern suggests that the measurement model is empirically adequate, although some constructs are measured more strongly than others. Taken together with the reliability results, these findings indicate that the indicators generally represent their intended latent concepts consistently and provide sufficient measurement quality for subsequent structural analysis.

Establishing convergent validity is insufficient if theoretically distinct constructs cannot be empirically distinguished from one another. Discriminant validity was therefore assessed using the heterotrait–monotrait ratio of correlations. This examination is especially important in the present model because several hospital attributes may be conceptually related. Patients who perceive a hospital as financially accessible, for example, may simultaneously evaluate its insurance arrangements, treatment costs, institutional characteristics, and overall attractiveness. Discriminant validity assessment determines whether such related concepts remain sufficiently distinct to justify their treatment as separate explanatory constructs.

The HTMT results require more cautious interpretation than the preceding reliability and convergent-validity findings. Although several construct pairs exhibit clear empirical separation, a

number of coefficients are unusually high, indicating substantial shared variance among some hospital-related constructs. The strongest overlaps involve combinations of treatment cost, hospital facilities, hospital type, insurance options, and the patient decision construct. This pattern suggests that respondents may not have distinguished some dimensions of hospital choice as sharply as the conceptual model assumes. Before drawing strong conclusions from individual structural paths, the measurement specification should therefore be examined further through indicator wording, cross-loadings, construct conceptualization, and bootstrapped HTMT inference where available. Establishing stronger construct distinctiveness is important because excessive overlap can make individual path coefficients difficult to interpret as genuinely separate effects.

After evaluating the measurement model, the analysis proceeded to the explanatory capability of the structural model. The coefficient of determination assesses how much variation in patients' hospital-choice decisions is jointly accounted for by the predictors included in the model. This assessment is useful because statistical significance alone does not reveal whether the proposed framework provides a meaningful explanation of the dependent construct. The adjusted coefficient is particularly informative in a model containing several predictors because it accounts for model complexity and reduces the inflation that may occur when additional explanatory variables are introduced. Table 5 presents the explanatory capacity of the structural model.

The results indicate that the proposed model explains a substantial proportion of variation in patients' hospital-choice decisions. The small difference between the unadjusted and adjusted coefficients also suggests that the model retains its explanatory strength after accounting for the number of predictors. This supports the substantive relevance of examining hospital choice as a multidimensional decision involving financial, service, operational, institutional, and patient-level considerations. The result should, however, be interpreted as evidence of strong in-sample explanatory capability rather than proof of predictive accuracy. Claims regarding out-of-sample prediction would require additional procedures such as predictive relevance assessment or PLSpredict.

Beyond statistical significance, hospital management requires information about which attributes deserve managerial attention. Importance–Performance Map Analysis extends the structural model by considering both the contribution of each antecedent to the target construct and its observed performance. This approach is useful because an attribute may perform well but have limited influence on hospital choice, while another may exert substantial influence and therefore warrant continued managerial investment. IPMA consequently translates structural-model results into a more decision-oriented interpretation by distinguishing factors that should be maintained from those for which additional resources may generate limited incremental benefit. Table 4 summarizes the importance and performance configuration of the study variables.

Table 4. IPMA Result of Importance and Performance

Construct	Importance	Performance
Treatment Cost	0.006	81.402
Hospital Facilities	0.106	78.034
Hospital Type	0.094	78.410
Service Quality	0.954*	81.650
Insurance Options	0.246	79.504
Waiting Time	0.079	74.271

Source: Adapted Smartpls 4 Data (2025)

The IPMA pattern indicates that managerial priorities should not be determined by performance scores alone. Service quality and insurance options combine comparatively strong importance with high performance, making them strategically consequential components of hospital choice that should be protected and continuously maintained. Several other hospital characteristics display relatively favorable performance but weaker importance, implying that additional investment in these dimensions may produce smaller marginal gains in patient preference unless specific deficiencies are identified. Demographic characteristics generally have limited managerial actionability and should be interpreted primarily as contextual variables rather than direct targets for service intervention. Because IPMA importance is normally derived from total structural effects, the importance values should also be cross-checked against the structural

model specification before final managerial conclusions are drawn, particularly where the resulting importance ordering differs markedly from the direct path coefficients.

Table 5. Model Coefficient

Paths	Path	t-value	p-value
Medical expenses -> Patient's decision to choose a hospital	0,006	0,100	0,460
Hospital facilities -> Patient's decision to choose a hospital	0,152	3,005	0,001
Hospital type -> Patient's decision to choose a hospital	0,135	2,621	0,004
Service quality -> Patient's decision to choose a hospital	0,198	3,504	0,000
Insurance options -> Patient's decision to choose a hospital	0,355	5,395	0,000
Waiting time -> Patient's decision to choose a hospital	0,114	2,520	0,006
Age -> Patient's decision to choose a hospital	0,031	1,158	0,123
Degree -> Patient's decision to choose a hospital	0,078	3,366	0,000
Gender -> Patient's decision to choose a hospital	0,019	0,832	0,203
Payment -> Patient's decision to choose a hospital	-0,002	0,069	0,473
Income -> Patient's decision to choose a hospital	0,090	4,249	0,000

Source: Adapted Smartpls 4 Output (2025)

The final stage of the structural analysis evaluates the hypothesized relationships between hospital attributes, patient characteristics, and hospital-choice decisions. Bootstrapping was used to assess whether the estimated relationships were sufficiently stable to differ from zero across repeated resamples. This procedure provides the inferential basis for determining which predictors contribute meaningfully to hospital choice after the other variables in the model are considered simultaneously. The resulting path coefficients should therefore be interpreted not merely as isolated associations, but as the unique contribution of each predictor within the full structural configuration.

DISCUSSION

The findings show that patients' hospital choice in Jakarta is shaped primarily by insurance accessibility, service quality, hospital facilities, hospital type, and waiting time, while treatment cost does not independently determine hospital selection. This pattern suggests that patients evaluate hospitals through a broader assessment of accessibility, service experience, institutional capability, and operational convenience rather than through price alone. Insurance options emerge as particularly influential because they reduce uncertainty surrounding treatment expenses and determine whether patients can realistically access particular providers. This interpretation is consistent with Andoh-Adjei et al. (2018), who showed that financing arrangements can shape healthcare participation, although their effects may depend on other contextual factors. Insurance therefore operates not merely as a payment instrument but as an access mechanism that reduces financial exposure and allows patients to focus more directly on obtaining treatment.

Hospital facilities also contribute meaningfully to hospital choice. Patients appear to interpret physical infrastructure, medical equipment, supporting amenities, and service environments as tangible signals of institutional capability. This finding is consistent with Kamra et al. (2016), who identified the availability of essential facilities, pharmacies, parking, waiting areas, and other supporting infrastructure as relevant considerations in hospital selection. However, the importance of facilities should not be interpreted independently from the broader service experience. Previous evidence has shown that facilities may be associated with healthcare selection at the bivariate level but lose explanatory strength once other attributes are considered simultaneously. This suggests that sophisticated facilities can attract patients, but their strategic value depends on how effectively they support reliable, comfortable, and accessible healthcare delivery.

Service quality provides an even stronger explanation of hospital choice because patients experience healthcare through continuous interactions with physicians, nurses, administrative personnel, and supporting staff. The result is consistent with Anggraheni (2012), who found that service quality contributes to patients' selection of healthcare providers. Patients are therefore unlikely to judge hospitals solely through physical resources. Responsiveness, empathy,

reliability, clarity of communication, professional conduct, and the ability to provide efficient care transform hospital resources into an actual service experience. Higher service quality can strengthen confidence in the provider and reduce the perceived risk associated with treatment. In a competitive urban healthcare market, this makes service quality a strategic differentiator rather than merely an operational outcome.

Waiting time also influences hospital choice, highlighting the importance of operational efficiency in the patient experience. Patients incur not only medical costs but also time, inconvenience, uncertainty, and opportunity costs when accessing healthcare. Prolonged or unpredictable waiting can therefore reduce the perceived value of otherwise adequate clinical services. This finding aligns with Tinaningsih et al. (2024), who linked waiting time with patient satisfaction and subsequent reuse of hospital services. Efficient waiting-time management can strengthen patients' willingness to return because it signals effective scheduling, sufficient service capacity, and organizational responsiveness. Hospitals should therefore treat waiting time as part of service quality rather than as a purely administrative indicator.

Hospital type also contributes to patients' decisions, indicating that institutional identity provides information that patients use before directly experiencing care. Public and private hospitals may generate different expectations regarding affordability, service speed, facilities, specialist availability, and administrative convenience. Windarti (2022) similarly demonstrated the relevance of hospital identity in healthcare selection, while Kamra et al. (2016) showed that hospital brand, physician reputation, institutional image, organizational history, cultural considerations, and specialist availability can shape hospital choice. The finding is not universal, however, because Nurliyah and Rahmadani (2023) reported no significant relationship between hospital type and healthcare selection. This difference reinforces the context-dependent nature of institutional preference. Patients may attach different meanings to hospital type depending on available alternatives, insurance coverage, medical needs, accessibility, and prior experience. Hospital type should therefore be understood as an institutional signal whose relevance depends on the healthcare environment in which the choice occurs.

In contrast, treatment cost does not independently influence hospital choice in the present study. This result differs from Ditasari et al. (2019), who found that lower medical costs were associated with healthcare selection in another Indonesian setting. The divergence is theoretically important because it suggests that nominal price and actual financial accessibility are not equivalent. In Jakarta, patients may evaluate whether treatment can be covered through insurance or other financing mechanisms rather than focusing exclusively on the stated price of medical services. Once insurance accessibility, service quality, facilities, and institutional characteristics are considered simultaneously, treatment cost may lose explanatory importance. The finding therefore does not imply that cost is irrelevant to healthcare consumption; rather, its influence may be absorbed or conditioned by broader mechanisms that determine the patient's actual financial burden.

The findings concerning demographic characteristics are more differentiated than a general demographic effect would imply. Age, gender, and payment type do not independently explain hospital selection, whereas education and income contribute to differences in patient choice. Ditasari et al. (2019) similarly found that several respondent characteristics did not determine hospital selection, suggesting that patients may prioritize provider attributes over basic demographic profiles. Education and income, however, can influence the resources available for evaluating alternatives, expectations regarding service standards, and the range of hospitals that patients can realistically consider. The findings therefore indicate that demographic characteristics should not be treated as a homogeneous explanatory category. Some patient characteristics provide meaningful segmentation information, while others contribute little once hospital-level attributes are incorporated into the model.

This broader interpretation is consistent with Singh et al. (2022), who identified medical competence, supporting services, institutional reputation, service costs, location, and infrastructure as important components of hospital choice. Taken together, the present findings portray hospital selection as a multidimensional decision in which patients combine financial accessibility, service experience, institutional signals, infrastructure, and operational efficiency. The absence of a direct treatment-cost effect strengthens this interpretation because patients appear to distinguish between the nominal price of healthcare and their practical ability to access it. For hospital managers, the implication is clear: competitive advantage is unlikely to come from

price reductions alone. Greater strategic value lies in strengthening insurance accessibility, maintaining service quality, ensuring adequate facilities, improving patient-flow efficiency, and building an institutional profile that patients associate with dependable and accessible care.

CONCLUSION AND FURTHER STUDY

This study shows that patients' hospital choice in Jakarta is shaped less by treatment price alone than by the broader accessibility and quality of the healthcare experience. Insurance options, service quality, hospital facilities, hospital type, and waiting time meaningfully influence hospital selection, while treatment cost does not exert an independent effect. The findings indicate that patients assess hospitals through a combination of financial access, institutional capability, service reliability, and operational convenience. Education and income also differentiate patient choice, whereas age, gender, and payment type contribute little once hospital attributes are considered simultaneously. These results extend hospital-choice research by showing that urban patients respond to the total configuration of access and service value rather than to isolated cost considerations. For hospital managers, the strongest strategic priority is therefore to strengthen insurance accessibility, service quality, facility readiness, and patient-flow efficiency to create a more dependable and attractive healthcare experience.

ETHICAL DISCLOSURE

This study involved human participants and was conducted in accordance with the ethical principles of the Declaration of Helsinki. Ethical clearance was obtained from the relevant institutional research ethics committee prior to data collection. No personally identifying information was collected, and all data were stored and analyzed in anonymized form.

CONFLICT OF INTEREST

The authors declare no conflict of interest with respect to the research, authorship, and/or publication of this article.

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