Brand or Experience Driven? Dual Pathways to Patient Loyalty in Healthcare

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Jambura Science Of Management

JSM
Volume 8
Number 2
July 2026

Received on 16 Jul 2026

Revised on 27 Jul 2026

Accepted on 5 Aug 2026

DOI: 10.37479

ABSTRACT

***Purpose*:** This study investigates whether brand awareness shapes patient loyalty through the mediating roles of patient satisfaction and patient engagement, and whether this mechanism differs between BPJS (national health insurance) and non-BPJS patients of a private hospital network in Bali, Indonesia. The study draws on Expectation-Confirmation Theory (ECT) to explain how cognitive and relational pathways translate brand recognition into long-term loyalty.

Design/Methodology/Approach: A quantitative comparative survey was conducted among 150 patients of RS. Kasih Ibu Bali (75 BPJS and 75 non-BPJS), selected through purposive sampling across four hospital branches. Data were collected with a validated 24-item, five-point Likert questionnaire and analyzed using Partial Least Squares Structural Equation Modeling (PLS-SEM) in SmartPLS 4, followed by Measurement Invariance of Composite Models (MICOM) and Multi-Group Analysis (MGA) using Henseler's nonparametric test and permutation procedures.

***Findings*:** For BPJS patients, brand awareness directly and strongly predicted loyalty, while satisfaction and engagement played no significant role. For non-BPJS patients, the opposite pattern emerged: brand awareness had no direct effect on loyalty, whereas satisfaction and engagement were the dominant drivers. Satisfaction mediated the brand awareness-loyalty link significantly only among non-BPJS patients, while serial mediation through satisfaction and engagement together was not supported in either group. These results indicate that patient loyalty in a two-tier healthcare financing context follows two structurally distinct psychological routes: a brand-driven route for BPJS patients and an experience-driven for non-BPJS patients. Practical implications for differentiated hospital marketing and service-quality strategies are discussed.

Keywords: *Brand Awareness; Patient Satisfaction; Patient Engagement; Patient Loyalty; Multi-Group Analysis*

INTRODUCTION

Hospital competition has intensified worldwide as patients increasingly evaluate healthcare providers as they do retail brands, weighing not only clinical competence but also communication, convenience, and emotional engagement (Adams et al., 2024; Kar & Kaya, 2026). A hospital brand, however, does not translate into loyalty through a single, uniform mechanism. Some patients remain loyal on the strength of the brand itself, choosing and re-choosing a provider on recognition and reputation alone; others commit only once the brand's promise has been tested and confirmed through actual service encounters. This paper advances and tests a dual-pathway proposition: patient loyalty in healthcare is not produced by one mechanism that varies in strength, but by two structurally distinct routes: a brand-driven route, in which recognition itself is sufficient to secure loyalty, and an experience-driven route, in which loyalty forms only after the brand's promise is confirmed through satisfaction and engagement. This distinction is the organizing argument of the study, not a finding reserved for the results section. Private hospitals worldwide have already begun acting on this logic, treating brand equity and patient loyalty as strategic levers for long-term competitiveness (Irawan et al., 2025), a shift reinforced by rising cross-border patient mobility now reported in more than 70 percent of countries as a signal of consumers' growing orientation toward perceived value in healthcare (Kar & Kaya, 2026).

The Southeast Asian private-hospital sector demonstrates how fast this competitive logic has taken hold: annual growth of roughly 9.2 percent has driven hospitals to invest more heavily in brand-based differentiation (Supriadi et al., 2024). Brand awareness strengthens perceived value and revisit intention (Fong & Goh, 2021), but this effect is conditional, not automatic. Kumar et al. (2024) show that awareness delivers its full effect only when followed by a positive emotional experience (satisfaction, engagement, or both), which means recognition alone is an incomplete predictor of loyalty. Patients today judge hospitals holistically: experience quality, communication, and emotional involvement now function as central, not peripheral, determinants of loyalty (Adams et al., 2024).

Indonesia mirrors this pattern at a national scale. Private hospitals now number more than 1,700 units. However, the average patient-satisfaction rate stands at only about 78.3 percent (Badan Pusat Statistik Indonesia, 2024), leaving clear room for improvement, particularly in patients' sense of involvement in their own care (Ubery & Ernawaty, 2024). The same tension is visible at RS. Kasih Ibu Bali is a private hospital network operating four branches in Kedonganan, Denpasar, Saba, and Tabanan. Outpatient and inpatient retention ratios fluctuated throughout 2025 without settling at a stable level, and

internal service surveys recorded complaint ratios of 15 to 25 percent of total monthly surveys. Non-medical complaints (administrative speed, queuing systems, facility cleanliness, staff friendliness) accounted for roughly 83 percent of all complaints, against only 17 percent tied to medical matters. Clinical competence, in other words, remains intact; what falls short is functional service quality, and it is the totality of the service experience, not clinical outcomes alone, that determines how patients judge their loyalty to the hospital (Setiawati & Lailiyah, 2023).

A further, decisive layer of complexity concerns the heterogeneity between patients enrolled in Indonesia's national health insurance scheme, Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS), and those who pay independently or through private insurance (non-BPJS). The two groups hold different service expectations by design, not by coincidence (Huang et al., 2021): non-BPJS patients, who generally command greater economic capacity, expect comfort, responsiveness, and personalized care, while BPJS patients prioritize affordability and certainty of access. This is precisely where the dual-pathway proposition becomes testable rather than speculative. The BPJS referral structure narrows patients' practical choice set, so brand familiarity alone can function as a sufficient anchor for loyalty regardless of lived experience; non-BPJS patients, free to compare providers and free to leave, cannot be retained on recognition alone; their loyalty must be earned through confirmed experience. These divergent value orientations are the structural condition that produces two distinct patterns of satisfaction, engagement, and loyalty formation across the two segments (Górska-Warsewicz, 2022; Rather et al., 2018), a divergence that most existing hospital-marketing studies have not explicitly tested, and that this study treats as its central object of inquiry.

Expectation-Confirmation Theory (ECT), originally proposed by Oliver (1980) and later extended by Bhattacherjee (2001), supplies the theoretical mechanism that explains why the two pathways diverge. ECT holds that satisfaction arises when actual performance confirms or exceeds prior expectations, and that brand awareness is one of the principal forces shaping those initial expectations (Ramasamy et al., 2024). A hospital with strong brand awareness cultivates expectations about medical competence and service reliability (Maulana & Ayuningtyas, 2023); when the lived experience confirms these expectations, positive confirmation strengthens patient engagement (Barzallo et al., 2021) and drives loyalty through repeat visits and recommendations (Tobler & Stummer, 2021). Because BPJS and non-BPJS patients enter the service encounter with different baseline expectations and different freedom to act on disconfirmation, the confirmation process and the loyalty mechanism it produces cannot be uniform across the two groups (Ramasamy et al., 2024). This is the theoretical basis on which

the brand-driven and experience-driven routes are expected to operate for different segments of the same patient population.

Satisfaction, once formed, does not automatically convert into loyalty. A growing body of research treats patient engagement (the cognitive, emotional, and behavioral investment patients make in their relationship with a provider) as a second, parallel mechanism that, in some contexts, drives loyalty more decisively than satisfaction itself (Yağar et al., 2025; Sieck et al., 2023). Satisfied patients develop stronger trust and affective bonds (Bentum-Micah et al., 2024), and it is this engagement, more often than satisfaction alone, that ultimately consolidates repeat patronage and advocacy (Omaghomi et al., 2024; Pansari & Kumar, 2022). The experience-driven pathway therefore rests on two mediators, satisfaction and engagement, whose relative weight is itself expected to differ between BPJS and non-BPJS patients.

Despite this theoretical groundwork, studies that jointly examine brand awareness, satisfaction, engagement, and loyalty within a single hospital-based model remain scarce (Guha Roy et al., 2023). Most existing evidence originates from retail or banking settings (Singh et al., 2021) rather than healthcare, where dual-mediation pathways involving both satisfaction and engagement are rarely tested together (Pan & Chen, 2025). This gap is sharper still in developing countries such as Indonesia, whose institutional and behavioral context differs substantially from that of advanced economies (Górska-Warsewicz, 2022). Two research gaps follow directly: first, the scarcity of studies testing a dual-mediation model of brand awareness, satisfaction, engagement, and loyalty in a hospital setting; second, the absence of empirical evidence from developing countries capturing the distinctive characteristics of local patient behavior across different health-financing segments.

This study addresses this gap by conducting a comparative analysis of how brand awareness influences patient loyalty through patient satisfaction and engagement among BPJS and non-BPJS patients at Kasih Ibu Hospital in Bali. Specifically, this study examines whether the direct effects of brand awareness, satisfaction, and engagement on loyalty, along with their simple and serial mediating roles, differ significantly between these two patient segments (Figure 1). Thus, this study extends the ECT into a segmented dual-mediation framework and offers evidence-based guidance for hospital managers seeking to design distinct loyalty-building strategies for both insured (BPJS) and self-paying patients (Non-BPJS).

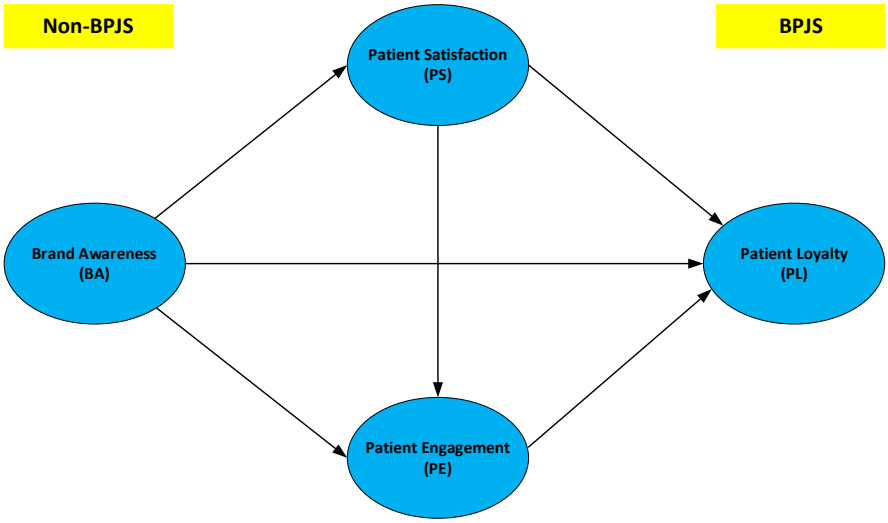

Figure 1. Research Conceptual Framework
Source: Compiled by the researcher (2026)

METHODS

This study employed a quantitative, comparative, cross-sectional survey design to test causal relationships among brand awareness, patient satisfaction, patient engagement, and patient loyalty at RS. Kasih Ibu Bali is a private hospital network with four branches across Bali (Creswell & Creswell, 2018). The research adopted a positivist, explanatory paradigm consistent with theory-driven hypothesis testing under Expectation-Confirmation Theory (Hair et al., 2019). It examined both a pooled sample and two comparison groups defined by health-financing scheme, namely BPJS participants and non-BPJS (self-paying or privately insured) patients.

The study population comprised all patients who had used RS. Kasih Ibu Bali's outpatient or inpatient services within the preceding six months, a period chosen to minimize recall bias while ensuring sufficiently recent service experience (Batbaatar et al., 2017). Because the exact population size fluctuates around 26,000 visits per month and could not be determined precisely, the minimum sample size was estimated using G*Power 3.1 with an a priori F-test for multiple linear regression (fixed model, R^2 increase; effect size $f^2 = 0.15$; $\alpha = 0.05$; power = 0.95), yielding a minimum requirement of 119 respondents (Faul et al., 2009). Anticipating a 20 percent dropout allowance, the target sample size was set at 150 respondents, divided evenly into 75 BPJS patients and 75 non-BPJS patients. This even split was adopted deliberately to ensure comparability between the two segments and to satisfy the group-size requirement for multi-group comparative analysis. Respondents were then distributed disproportionately across the four branches (Kedonganan, Denpasar, Saba, and Tabanan; the Denpasar branch does not serve BPJS patients) to reflect each location's actual patient composition.

Respondents were recruited through non-probability purposive sampling (Etikan et al., 2016), based on the following inclusion criteria: (1) at least 18 years of age and cognitively able to complete the questionnaire independently; (2) had used RS. Kasih Ibu Bali's services at least twice within the preceding six months, ensuring sufficient experience to evaluate the hospital's brand and service quality; and (3) willing to participate voluntarily and provide informed consent (Stimson, 2014). Patients in critical or intensive care, and those with cognitive impairments precluding valid responses, were excluded (Sedgwick, 2015). A mixed-mode data-collection strategy combined paper-based questionnaires distributed on site with an online version administered through Google Forms and shared via email or messaging applications to raise response rates and reduce non-response bias (Dillman et al., 2014).

Four constructs were measured using six-item, five-point Likert scales (1 = strongly disagree to 5 = strongly agree), adapted from previously validated instruments. Brand awareness (BA) was adapted from Davcik and Garg (2021) and Guha et al. (2023), covering hospital name recall, logo recognition, perceived quality, knowledge of flagship services, reputation, and market positioning. Patient satisfaction (PS) was adapted from Batbaatar et al. (2017) and Qin et al. (2020), covering satisfaction with medical professionalism, staff empathy, facility comfort, administrative efficiency, treatment outcomes, and overall service. Patient engagement (PE) was adapted from Islam et al. (2020) and Rather (2018), covering functional reliance on the hospital, emotional connection, pride in using its services, active participation in health programs, willingness to provide feedback, and pride of belonging to the patient community. Patient loyalty (PL) was adapted from Zeithaml et al. (1996) as validated by Gong and Yi (2018), covering repurchase intention, prioritization of the hospital, willingness to recommend, resistance to switching, relationship maintenance, and forgiveness toward occasional service lapses.

Instrument calibration was carried out on a pilot sample of 39 patients drawn disproportionately from the four branches prior to full-scale distribution. Item validity was assessed through Pearson correlation, with an item considered valid at a coefficient above 0.30, and reliability was assessed using Cronbach's alpha, with an acceptable threshold above 0.60 (Fowler, 2014). All items across the four constructs met both criteria, confirming that the instrument was suitable for full deployment.

Data were analyzed in two layers using SmartPLS 4 (Ringle et al., 2023). First, Partial Least Squares Structural Equation Modeling (PLS-SEM) was applied to the pooled sample, comprising measurement-model assessment (convergent validity via outer loadings ≥ 0.70 and Average Variance Extracted ≥ 0.50; discriminant

validity via the Heterotrait-Monotrait ratio below 0.90; and internal-consistency reliability via Cronbach's alpha and composite reliability between 0.70 and 0.95) followed by structural-model assessment (coefficient of determination R^2, effect size f^2, predictive relevance Q^2 via blindfolding, and path significance via 10,000-resample two-tailed bootstrapping at $\alpha = 0.05$) (Hair et al., 2021). Mediation was tested through bootstrapped specific indirect effects rather than the Sobel test, given its robustness to non-normal sampling distributions (Hayes & Rockwood, 2023); simple mediation was examined along the paths BA→PS→PL and BA→PE→PL, while serial mediation was examined along BA→PS→PE→PL, following the guidance of Preacher and Hayes (2023).

Second, a multi-group comparison followed the procedure outlined by Vinzi et al. (2009): data preparation and quality checks, creation of the BPJS and non-BPJS grouping variable, and Measurement Invariance of Composite Models (MICOM), comprising configural invariance (identical indicators, data treatment, and algorithm settings across groups), compositional invariance (permutation-based correlation test, $p > 0.05$), and, where applicable, full or partial equality of composite means and variances. Once at least partial invariance was established, Multi-Group Analysis (MGA) was performed using two complementary nonparametric procedures, Henseler's PLS-MGA and a permutation test, to determine whether path coefficients differed significantly (p-diff < 0.05) between BPJS and non-BPJS patients across all nine hypothesized relationships.

RESULTS

The final sample comprised 150 respondents, evenly split between BPJS (n = 75) and non-BPJS (n = 75) patients. Women were more prevalent in both groups (53.3 percent in the BPJS group and 65.3 percent in the non-BPJS group), consistent with typically higher healthcare utilization among women. Age profiles diverged: BPJS respondents were concentrated in the 45-54 age band (37.3 percent), whereas non-BPJS respondents were concentrated in the 25-34 age band (38.7 percent), suggesting that older patients rely more on social insurance while younger, working-age patients more often self-pay. Educational attainment also differed, with senior-high-school graduates dominating the BPJS group (42.7 percent) and bachelor's-degree holders dominating the non-BPJS group (48.0 percent), broadly consistent with the association between education, income, and the ability to self-finance care. Private-sector employees were the largest occupational category in both groups (68.0 percent BPJS; 57.3 percent non-BPJS). Outpatient care was the most common service type overall (61.3 percent). In comparison, non-BPJS patients showed a higher share of inpatient stays (37.3 percent versus 28.0 percent) and of visits exceeding six times (24.0 percent versus 14.7 percent),

indicating comparatively freer and more frequent access to hospital services outside the tiered BPJS referral system.

Descriptive analysis showed that all four constructs were perceived at high to very-high levels. Brand awareness averaged 4.18 (SD = 0.786), with perceived service quality (BA3, mean = 4.25) rated highest and knowledge of flagship services (BA4) and hospital reputation (BA5) rated comparatively lowest (mean = 4.15 each). Patient satisfaction averaged 4.22 (SD = 0.809), led by satisfaction with facility comfort (PS3, mean = 4.31) and trailed by satisfaction with administrative efficiency (PS4, mean = 4.13), signaling a persistent, if moderate, weakness in administrative processes. Patient engagement averaged 4.32 (SD = 0.690), the highest of the four constructs, led jointly by reliance on the hospital for health needs (PE1) and pride of community belonging (PE6, both mean = 4.37). In contrast, active participation in health programs (PE4, mean = 4.17) lagged behind the more affectively oriented items. Patient loyalty averaged 4.23 (SD = 0.780), led by hospital prioritization (PL2, mean = 4.33) and trailed by intention to return for future healthcare needs (PL1, mean = 4.13), a pattern plausibly explained by the situational, need-driven nature of hospital revisits rather than by weak loyalty per se.

The measurement model met all recommended thresholds. Outer loadings for all 24 indicators ranged from 0.783 to 0.891, comfortably above the 0.70 benchmark, and Average Variance Extracted ranged from 0.682 (patient engagement) to 0.735 (patient satisfaction), all exceeding 0.50. Discriminant validity, assessed through the Heterotrait-Monotrait ratio, ranged from 0.743 to 0.848, below the 0.90 threshold, confirming that the four constructs were empirically distinct. Internal-consistency reliability was strong across all constructs, with Cronbach's alpha and composite reliability both falling between 0.907 and 0.928 (Table 1).

Table 1. Summary of Measurement Model Assessment

Construct	Outer Loading Range	AVE	Cronbach's Alpha / CR
Brand Awareness (BA)	0.807 - 0.891	0.725	0.924 / 0.925
Patient Satisfaction (PS)	0.819 - 0.886	0.735	0.927 / 0.928
Patient Engagement (PE)	0.783 - 0.863	0.682	0.907 / 0.908
Patient Loyalty (PL)	0.792 - 0.874	0.713	0.919 / 0.920

Source: Primary data, processed with SmartPLS 4 (2026)

In the structural model, brand awareness explained a moderate share of variance in patient satisfaction ($R^2 = 0.618$) and patient engagement ($R^2 = 0.584$), and a comparatively stronger share of variance in patient

loyalty (R^2 = 0.697), approaching the strong category. Predictive relevance was very high (Q^2 = 0.952). Effect-size analysis (f^2) revealed that brand awareness exerted a very large effect on patient satisfaction (f^2 = 1.617), far above the 0.35 threshold for a large effect. In contrast, its direct effects on loyalty (f^2 = 0.053) and on engagement's effect on loyalty (f^2 = 0.097) were small, foreshadowing the central mediating role of satisfaction and engagement in the overall model (Figure 2).

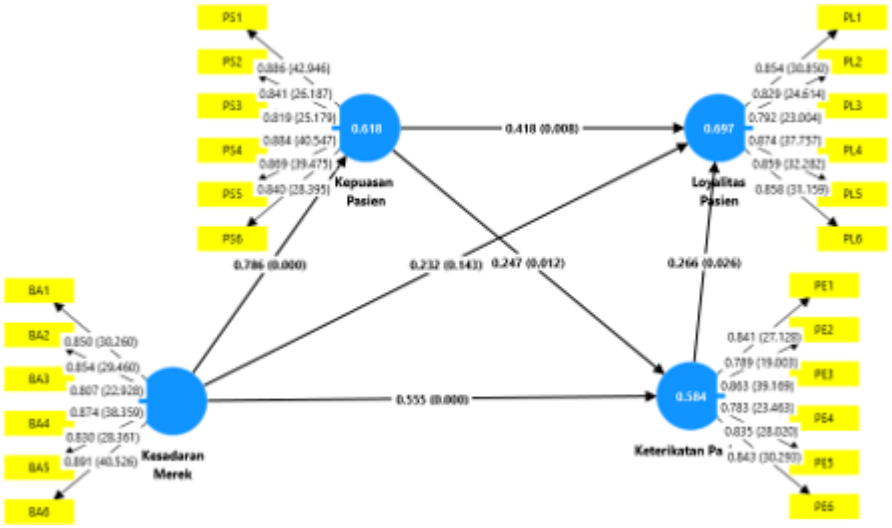

Figure 2. Analysis Results Model (Bootstrapping)
Source: Primary data, processed with SmartPLS 4 (2026)

For the pooled sample, brand awareness did not directly predict patient loyalty (β = 0.232; t = 1.463; not significant), but strongly and significantly predicted both patient satisfaction (β = 0.786; t = 12.492) and patient engagement (β = 0.555; t = 5.964). Patient satisfaction in turn significantly predicted both engagement (β = 0.247; t = 2.514) and loyalty (β = 0.418; t = 2.653), and patient engagement significantly predicted loyalty (β = 0.266; t = 2.230). Bootstrapped indirect-effect tests confirmed that satisfaction fully mediated the brand awareness-loyalty relationship (indirect β = 0.328; t = 2.717), as did engagement (indirect β = 0.148; t = 2.230), whereas the three-path serial mediation through satisfaction and then engagement was not significant (indirect β = 0.052; t = 1.465). Overall, at the pooled level, brand awareness converts into loyalty only through the cognitive-evaluative route of satisfaction or the affective-relational route of engagement, not through direct brand recognition alone, and not through a sequential chain of both mediators together.

Measurement invariance testing (MICOM) indicated at least partial invariance across the BPJS and non-BPJS groups: configural invariance was fully satisfied, and compositional invariance held for satisfaction, brand awareness, and loyalty on the correlation and

variance criteria, while engagement met invariance only on the mean criterion. This level of invariance was sufficient to proceed with Multi-Group Analysis.

The multi-group comparison revealed markedly divergent structural patterns between the two segments (Table 2). Among BPJS patients, brand awareness exerted a strong, significant direct effect on loyalty ($\beta = 0.751$; $p = 0.000$) and on satisfaction ($\beta = 0.860$; $p = 0.000$), and a significant effect on engagement ($\beta = 0.424$; $p = 0.009$), while satisfaction ($\beta = 0.016$; $p = 0.907$) and engagement ($\beta = 0.125$; $p = 0.331$) showed no significant effect on loyalty. Among non-BPJS patients, brand awareness again strongly predicted satisfaction ($\beta = 0.714$; $p = 0.000$) and engagement ($\beta = 0.593$; $p = 0.000$), but its direct effect on loyalty was not significant ($\beta = 0.021$; $p = 0.915$); instead, both satisfaction ($\beta = 0.548$; $p = 0.004$) and engagement ($\beta = 0.362$; $p = 0.016$) significantly predicted loyalty.

Table 2. Multi-Group Analysis: Path Coefficients and Hypothesis Testing (BPJS vs Non-BPJS)

Path	BPJS (β / p)	Non-BPJS (β / p)	p-diff	Result
BA -> PL	0.751 / 0.000	0.021 / 0.915	0.004	Significant difference
BA -> PS	0.860 / 0.000	0.714 / 0.000	0.177	No significant difference
BA -> PE	0.424 / 0.009	0.593 / 0.000	0.367	No significant difference
PS -> PE	0.435 / 0.013	0.176 / 0.145	0.224	No significant difference
PS -> PL	0.016 / 0.907	0.548 / 0.004	0.035	Significant difference
PE -> PL	0.125 / 0.331	0.362 / 0.016	0.238	No significant difference
BA -> PS -> PL	0.014 / 0.908	0.391 / 0.011	0.051	Significant difference (marginal)
BA -> PE -> PL	0.053 / 0.416	0.215 / 0.020	0.153	No significant difference
BA -> PS -> PE -> PL	0.047 / 0.410	0.046 / 0.295	0.986	No significant difference

Note: BA = Brand Awareness; PS = Patient Satisfaction; PE = Patient Engagement; PL = Patient Loyalty. p-diff < 0.05 indicates a significant difference between groups (Henseler's PLS-MGA and permutation test).

Source: Primary data, processed with SmartPLS 4 (2026).

Hypothesis testing based on these group comparisons showed that the direct effect of brand awareness on loyalty differed significantly

between groups (|Δ| = 0.730; p-diff = 0.004), supporting the hypothesis that this path is stronger for BPJS patients. The effects of brand awareness on satisfaction (p-diff = 0.177) and on engagement (p-diff = 0.367) did not differ significantly, indicating that brand awareness builds both cognitive and affective evaluations similarly across payment schemes. The effect of satisfaction on engagement also did not differ significantly (p-diff = 0.224), despite being significant for BPJS patients but not for non-BPJS patients considered separately. By contrast, the effect of satisfaction on loyalty differed significantly between groups (|Δ| = 0.532; p-diff = 0.035), confirming that this path operates only among non-BPJS patients. The effect of engagement on loyalty did not differ significantly overall (p-diff = 0.238), even though it was significant only for non-BPJS patients when tested within-group. Among the indirect effects, the mediating role of satisfaction in the brand awareness-loyalty link differed significantly, at the conventional threshold, between groups (p-diff = 0.051), being strong for non-BPJS patients (β = 0.391; p = 0.011) and negligible for BPJS patients (β = 0.014; p = 0.908). The mediating role of engagement did not differ significantly between groups (p-diff = 0.153), although it, too, was significant only for non-BPJS patients (β = 0.215; p = 0.020) and not for BPJS patients (β = 0.053; p = 0.416). Finally, serial mediation through satisfaction and then engagement was negligible and statistically indistinguishable between the two groups (p-diff = 0.986), with both BPJS (β = 0.047; p = 0.410) and non-BPJS (β = 0.046; p = 0.295) patients showing no meaningful sequential transmission from brand awareness to loyalty.

DISCUSSION

The most consequential finding of this study is the sharply asymmetric role of brand awareness in shaping loyalty across the two patient segments. Among BPJS patients, brand awareness functioned as a near-sufficient condition for loyalty, operating largely independently of satisfaction or engagement. This pattern is consistent with an availability-heuristic and mere-exposure explanation (Romaniuk & Nenycz-Thiel, 2013). Once a hospital brand becomes easily accessible in memory, it tends to be evaluated positively and chosen again, particularly when the tiered referral structure of the national insurance system already narrows patients' choice set. Under such structural constraints, familiarity itself becomes an anchor of trust (Prentice et al., 2019), and loyalty can crystallize before, or largely independent of, direct service experience. This resonates with a broader argument in the literature that captive or quasi-captive consumers often display loyalty patterns driven more by institutional trust and habitual choice than by ongoing quality evaluation (Górska-Warsewicz, 2022).

Non-BPJS patients told a different story. For them, brand awareness remained an important entry point, consistently shaping both

satisfaction and engagement, but it stopped short of directly determining loyalty. Instead, loyalty in this segment was earned, not assumed: it required brand-driven expectations to be confirmed, or exceeded, by actual service quality (Huang et al., 2021), and it required an emotional bond to develop through repeated positive interaction. This is precisely the mechanism ECT predicts (Oliver, 1980; Bhattacherjee, 2001), and its clear presence here, contrasted with its virtual absence among BPJS patients, offers empirical evidence that ECT's explanatory power is not uniform across all healthcare consumers; rather, it is conditional on how much freedom a patient actually has to choose, compare, and, if dissatisfied, leave.

Interestingly, brand awareness's influence on satisfaction and on engagement did not differ significantly between the two groups, even though its influence on loyalty did. This suggests that brand awareness performs a genuinely cross-segment cognitive and affective function, shaping expectations and emotional identification similarly regardless of financing scheme, while the conversion of those internal states into behavioral loyalty follows two structurally distinct routes. Put differently, RS. Kasih Ibu Bali's brand appears to be a shared psychological resource. However, the two patient segments spend it differently: BPJS patients cash it in directly as loyalty, while non-BPJS patients first test it against lived experience.

The satisfaction-loyalty link, significant only among non-BPJS patients, deserves particular attention because it runs somewhat against a large body of healthcare-marketing literature in which satisfaction is treated as a near-universal predictor of loyalty (Sofia, 2023; Trisno & Berlianto, 2023; Supangat et al., 2022; Hamidah et al., 2025). The present findings do not contradict that literature so much as qualify it: satisfaction predicts loyalty robustly when patients bear the cost of switching and can meaningfully act on dissatisfaction, but its predictive power weakens, or disappears, when structural features of the health system, such as tiered referral requirements, limit the practical consequences of being dissatisfied. For BPJS patients, loyalty may persist even amid imperfect satisfaction simply because switching is costly or procedurally difficult, a possibility consistent with the broader idea that loyalty under constrained choice can be more captive than relational in nature.

A comparable, if less pronounced, pattern appeared for patient engagement. Although the difference in engagement's effect on loyalty across groups fell short of conventional significance, engagement was a significant predictor of loyalty only among non-BPJS patients. Emotional engagement, as Rather (2018) and Brodie et al. (2011) argue, is fundamentally a voluntary psychological investment; it requires patients to feel that continuing the relationship is their own choice, made freely rather than under institutional

constraint. This voluntariness condition appears easier to satisfy for patients who are, in fact, free to choose, which may explain why engagement translates into loyalty more readily for non-BPJS than for BPJS patients, even though brand awareness cultivates a comparable degree of engagement in both groups.

The mediation results reinforce this dual-pathway interpretation. Satisfaction mediated the brand awareness-loyalty relationship strongly among non-BPJS patients but negligibly among BPJS patients, a difference that reached significance at the conventional threshold. This indicates that for non-BPJS patients, the brand's promise must be redeemed through actual service quality before loyalty consolidates. In contrast, for BPJS patients, loyalty is comparatively insulated from that confirmation process. Engagement's mediating role followed a similar, though statistically weaker, pattern, being meaningful only for non-BPJS patients. Perhaps the most theoretically interesting null result is the absence of serial mediation, through satisfaction and then engagement, in either group. This finding departs from models that treat satisfaction and engagement as sequential links in a single causal chain (e.g., Sharma et al., 2020; Guru et al., 2024) and instead supports a parallel, complementary conception in which satisfaction and engagement represent two separate, non-sequential psychological routes from brand perception to loyalty (Pan & Chen, 2025). In a relationally intensive service context such as hospital care, loyalty appears to be reached by whichever route is activated first or most strongly, cognitive-evaluative or affective-relational, rather than by a compounding transfer from one mediator to the other.

Beyond the group comparison, the descriptive results point to specific service gaps worth managerial attention. Administrative efficiency recorded the lowest satisfaction score among all indicators, echoing the preliminary finding that non-medical complaints dominate the hospital's complaint records; this convergence between descriptive and confirmatory results strengthens the case that administrative friction, not clinical quality, is the more binding constraint on patient satisfaction at RS. Kasih Ibu Bali. Similarly, active participation in health programs trailed the more affectively oriented engagement indicators, suggesting that the hospital has cultivated emotional attachment more successfully than behavioral participation, a gap that, if closed, could plausibly strengthen the engagement-to-loyalty pathway that already operates strongly among non-BPJS patients.

Taken together, these findings extend ECT by demonstrating that its central confirmation mechanism is context-sensitive rather than universally applicable across healthcare consumers, contingent on the degree of choice freedom a patient actually possesses. They also contribute a segmented, dual-mediation perspective to the hospital-

branding literature, showing that a single loyalty-building strategy is unlikely to serve both financing segments equally well, and that treating patients as a homogeneous population, as much prior healthcare-marketing research implicitly does, risks masking structurally different loyalty mechanisms operating beneath a single average effect.

CONCLUSION

This study set out to determine whether brand awareness shapes patient loyalty through satisfaction and engagement differently between BPJS and non-BPJS patients of a private hospital network in Bali, and the evidence points to a clear answer: it does. BPJS patients build loyalty largely through direct brand recognition, a brand-driven pattern that relies less on satisfaction or emotional engagement, plausibly reflecting the constrained choice environment of the national referral system. In contrast, non-BPJS patients build loyalty through an experiential pathway, in which brand awareness first cultivates satisfaction and engagement. It is these two states, not brand familiarity itself, that ultimately consolidate loyal behavior. Brand awareness nonetheless remains foundational for both groups as a driver of satisfaction and engagement, and satisfaction and engagement operate as parallel rather than sequential mediators, since no evidence emerged for a serial chain running from satisfaction into engagement before loyalty forms.

Practically, these results caution RS. Kasih Ibu Bali and comparable private hospitals against applying a uniform loyalty strategy: for BPJS patients, sustained investment in institutional reputation, visual brand consistency, and accessible information may yield the most efficient return, whereas for non-BPJS patients, tangible improvements in administrative efficiency, staff empathy, and program-based engagement opportunities are likely to matter more directly for retention. Because the study relies on cross-sectional data from a single hospital network and a purposive sample that may already skew toward relatively loyal patients, these conclusions should be extended to other healthcare settings with appropriate caution, and future research is encouraged to replicate the model longitudinally, in public-hospital or primary-care contexts, and with additional boundary-condition variables such as institutional trust or doctor-patient communication quality.

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