Indonesian Journal of Medical Linguistics
Vol. 1, No. 3, September 2026, pp. 196~207
ISSN: 3163-3676, DOI: https://doi.org/10.67490/ijml.v1i3.946

Bureaucratic voice in hospital(ity)?: institutional language, patient confusion, and trust in Indonesian healthcare administration

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Article Info

Article history:

Received Aug 16, 2026
Revised Sep 13, 2026
Accepted Sep 30, 2026

Keywords:

Administrative discourse;
Bureaucratic voice;
Healthcare communication;
Patient confusion;
Trust.

ABSTRACT

Background: Healthcare administration in Indonesia increasingly mediates patient access through registration portals, queue systems, referral rules, identity verification, and digital health platforms, making bureaucratic language a crucial yet underexamined site of healthcare communication. **Objective:** This study examines how Indonesian hospital administration constructs institutional authority, generates patient confusion, and shapes trust through patient-facing administrative texts. **Method:** Using a qualitative discourse-pragmatic design, this study analyses 28 administrative utterance segments from publicly verifiable hospital, BPJS Kesehatan, SATUSEHAT, and Ministry of Health sources, supported by structured coding of institutional voice, comprehension risk, and trust/accountability functions. **Results:** Procedural sequencing is the most dominant bureaucratic pattern, indicating that hospital language primarily organizes patients through ordered steps, documents, queues, and eligibility checks. Confusion risk emerges most clearly in compressed procedures, unexplained acronyms, hidden prerequisites, and unclear agency, showing that administrative difficulty is produced by textual organization rather than patient deficiency alone. Trust cues appear mainly through direct action clarity and verification transparency, but repair pathways and relational reassurance remain limited. **Implication:** This study shows that patient-centred healthcare must include administrative texts through which patients first encounter institutional care. **Novelty:** This study advances medical-linguistic scholarship by conceptualizing hospital bureaucracy as a communicative actor whose textual voice organizes access, confusion, and trust before clinical interaction begins.

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1. INTRODUCTION

Indonesia's healthcare administration has become a decisive site where patients encounter hospitals before they encounter clinicians. This condition is socially consequential because bureaucratic language now mediates access to care at national scale: BPJS Kesehatan [1] reports 285,250,704 JKN participants, making administrative instructions, referral rules, queue systems, eligibility categories, and digital verification procedures part of everyday healthcare experience for a very large population. At the same time, health-system capacity remains pressured; World Bank [2] data report Indonesia at 1.4 hospital beds per 1,000 people in 2023, indicating that administrative navigation occurs within a constrained service environment.

Digital transformation intensifies this issue because SATUSEHAT [3] is designed to integrate individual health data across facilities and support electronic medical records, thereby expanding the role of system-facing terminology in patient-facing communication. This study is therefore necessary because hospital administration does not merely organize service flow; it speaks institutionally, and that voice may shape patient comprehension, procedural confidence, and trust.

Existing scholarship has examined several adjacent problems but has not sufficiently conceptualized hospital bureaucracy as a linguistic actor. Indonesian medical-linguistic studies have addressed informed consent jargon, rural doctor–patient directives, multilingual clinical barriers, empathic communication, emergency-care breakdowns, radiology simplification, and AI-mediated health advice [4], [5], [6], [7], [8], [9], [10]. International research likewise shows that patient-centred care depends on communicative involvement and relational responsiveness, while trust is shaped by security, transparency, and institutional reliability [11], [12], [13]. Studies of administrative procedures and patient satisfaction also indicate that service processes matter for trust in public hospitals [14]. Yet this literature has focused more on clinical interaction, satisfaction, or service quality than on how administrative texts themselves construct authority, assign responsibility, and produce confusion. This gap defines the entry point of this study.

This study investigates how Indonesian healthcare administration communicates through bureaucratic voice and how such communication may affect patient understanding and trust. It asks three interrelated questions. First, how is institutional authority linguistically constructed in patient-facing administrative materials such as registration instructions, referral requirements, queue procedures, complaint channels, and digital verification texts? Second, which textual features create potential confusion, especially through passive agency, nominalization, acronyms, eligibility conditions, procedural compression, and unexplained platform terminology? Third, how do these texts attempt to build or weaken trust through clarity, accountability, repair pathways, and patient-oriented explanation? These questions are addressed through a discourse-pragmatic analysis of publicly accessible administrative healthcare materials, supported by structured coding of bureaucratic voice, confusion risk, and trust cues. The inquiry does not treat confusion as individual deficiency; rather, it examines how institutional language distributes interpretive burden between hospitals, systems, and patients.

This study advances the argument that Indonesian hospital administration speaks in a bureaucratic voice that is efficient for institutions but not always legible for patients. Its working proposition is that administrative language may produce trust when it clarifies action, agency, consequence, and assistance, but may weaken trust when it compresses procedures into opaque requirements or relocates responsibility into systems, documents, and eligibility categories. This argument is consistent with Bueter and Jukola's [15] concern with institutional epistemic injustice in healthcare, where professional and organizational authority can marginalize patient understanding. It also extends patient-centred communication research by moving beyond bedside interaction toward the textual infrastructures that precede and surround care [16], [17]. The implication is theoretical and methodological: healthcare trust should be studied not only through attitudes, satisfaction, or clinical empathy, but also through the administrative grammar by which hospitals make access intelligible, conditional, or confusing.

2. LITERATURE REVIEW

2.1. Institutional language in healthcare

Institutional language in healthcare refers to patterned ways organizations formulate authority, obligation, eligibility, and procedure through texts, forms, announcements, digital interfaces, and spoken service encounters. Unlike clinical communication, which is often framed around interpersonal exchange, institutional language operates through impersonality, standardization, and rule-governed sequencing. Laila [4], Nurtyas [6], and Anandasari [8] show that medical meaning becomes difficult when expert terminology is not translated into patient-centred explanation. Nazulpa [5] and Nugroho [18] further indicate that institutional power is enacted pragmatically through directives and controlled disclosure. This literature suggests that healthcare language is never neutral; it organizes access, authority, and patient participation.

The main indicators of institutional language include passive agency, nominalization, procedural compression, acronyms, eligibility vocabulary, and system-dependent instruction. These indicators matter because they shift attention from who helps patients to what documents, platforms, or rules must be satisfied. Studies on Indonesian healthcare communication have emphasized jargon, multilingual barriers, radiology simplification, and AI-generated health responses as sites where expert language may exceed patient interpretive capacity [4], [6], [9], [10]. Internationally, goals-of-care communication research also stresses that clarity depends on explicit agency and shared understanding, not merely information transfer [17]. Institutional language is therefore best examined as a discourse structure.

2.2. Patient confusion in healthcare

Patient confusion in healthcare can be understood as communicative disorientation produced when patients cannot connect institutional instructions with actionable meaning. It differs from low knowledge

because confusion may arise even among literate patients when texts are procedurally dense, digitally mediated, or administratively fragmented. Escobedo et al. [20] show that language barriers may restrict access and understanding, while Nurtyas [6] and Anandasari [8] demonstrate similar risks in Indonesian multilingual and emergency-care contexts. Shaban [19] adds that virtual consultation may intensify asymmetry when patient narration is constrained by platform logic. Thus, confusion is not only cognitive; it is institutional, interactional, and infrastructural.

The indicators of patient confusion include unexplained acronyms, unclear sequencing, hidden prerequisites, ambiguous consequences, excessive document demands, and lack of repair pathways. These features are especially important in healthcare administration because patients often read instructions under stress, illness, waiting pressure, and uncertainty. Havana et al. [11] argue that patient-centred care depends on involvement and responsiveness, while Cipta et al. [16] emphasize culturally sensitive healthcare in low- and middle-income settings. Andayani [21] also shows that credibility and inequality shape whether patients' expressions are taken seriously. Together, these studies imply that confusion should be analysed as a communicative risk embedded in service design.

2.3. Trust in healthcare

Trust in healthcare refers to patients' confidence that institutions are competent, fair, responsive, and oriented toward their welfare. Trust differs from satisfaction: satisfaction evaluates experience after service, whereas trust anticipates whether patients believe the institution will guide, protect, and recognize them. Groves et al. [12] conceptualize security in hospital care as relationally produced, while Souvatzi et al. [13] link trust and mistrust to health crisis experience and institutional credibility. Hussain et al. [14], Rahman et al. [22], and Alfarizi and Arifian [23] connect administrative procedures, service quality, and loyalty. Yet trust remains underexplored as a textual effect of administrative communication.

Trust-oriented healthcare communication can be assessed through clarity, accountability, transparency, empathy, accessibility, and repairability. Rusita [7] and Rahman [24] foreground relational safety and empathy, whereas Bueter and Jukola [15] warn that institutional epistemic injustice may occur when organizational authority overrides patient understanding. Patient safety literature similarly shows that culture, speaking-up, and institutional learning shape whether healthcare systems become credible to those inside and outside them [25], [26], [27], [28]. This study therefore positions hospital administration as a textual infrastructure of trust, where bureaucratic voice can either clarify access or deepen patient uncertainty.

3. METHOD

The unit of analysis was the administrative utterance segment, defined as one complete patient-facing instruction, requirement, eligibility statement, queue rule, verification command, complaint pathway, or service explanation. This unit was selected because hospital bureaucracy rarely communicates through isolated words; it organizes patient action through sequences of documents, platforms, categories, and institutional conditions. The corpus comprised 31 metadata records and 28 analysable textual segments drawn from official public sources, including hospital websites, registration portals, BPJS Kesehatan manuals, SATUSEHAT/Kemenkes documentation, and peer-reviewed contextual literature. The dataset therefore captures healthcare administration as a textual infrastructure rather than as interpersonal clinical talk.

Table 1. Composition of dataset

Code Range	Data Type	Source	Location	Period	Quantity	Characteristics	Status
HBA-PRI-001–013	Primary	Official hospital/ministry/municipal service pages and portals	Surakarta, Surabaya, Bandung, Jakarta, Makassar	2023–2026; accessed 2026-07-09	13 documents; 20 text segments	Patient-facing registration, queue, referral, inpatient, telemedicine, and service-flow texts	Retained after deduplication
HBA-SEC-001–008	Secondary	BPJS Kesehatan Mobile JKN manuals; SATUSEHAT/Kemenkes documentation	National Indonesia	2023–2026; accessed 2026-07-09	8 documents; 8 text segments	Queue manuals, NIK/IHS identity documentation, privacy terms, RME registration guidance	Retained after deduplication
HBA-CTX-001–010	Context	Peer-reviewed journal articles supplied in reference base	Indonesia and international healthcare contexts	2021–2026	10 articles	Trust, patient-centred care, administrative procedures, epistemic injustice, patient safety	Used for interpretation
All corpus items	Integrated corpus	Publicly verifiable sources with URLs and metadata	Multi-site Indonesian healthcare administration	2021–2026	31 records; 28 coded segments	Text, quote, title, date, source, URL, context, visual fields where relevant	Cleaned and coded

This study used a qualitative discourse-pragmatic design with structured coding. The design is appropriate because this study does not measure actual patient comprehension or trust through surveys; instead, it examines textual conditions that may increase interpretive burden or support institutional intelligibility. This distinction prevents causal overclaiming and keeps the analysis aligned with available data. The design draws on medical-linguistic work on jargon, multilingual barriers, informed consent,

empathy, and digital health communication [4], [6], [10], [24]. It also follows healthcare communication scholarship that treats clarity, participation, and institutional responsiveness as central to patient-centred care [11], [17].

Information sources were divided into primary, secondary, and contextual data. Primary data consisted of administrative texts directly addressed to patients or service users, such as online registration portals, outpatient flow pages, inpatient rules, self-registration kiosk explanations, and municipal health-service interfaces. Secondary data consisted of national system documentation from BPJS Kesehatan and SATUSEHAT/Kemenkes, because these platforms shape how hospitals formulate registration, queueing, referral, identity verification, and digital health procedures. Contextual data consisted of scholarly literature on trust, administrative procedures, institutional epistemic injustice, patient safety, and Indonesian healthcare communication [15], [12], [14], [13].

Data collection followed a transparent documentary procedure. First, official institutional channels were identified using healthcare administration keywords such as “pendaftaran pasien,” “antrean BPJS,” “rujukan,” “SEP,” “NIK pasien,” “Mobile JKN,” “SATUSEHAT,” “rawat jalan,” “rawat inap,” and “komplain layanan.” Second, each eligible item was entered into a metadata sheet with source title, institution, date, region, URL, public-verifiability status, and inclusion reason. Third, patient-facing segments were copied into a text sheet with Indonesian excerpt, English gloss, context note, and visual fields where relevant. Fourth, duplicate or mirrored materials were removed or marked as contextual duplicates, preserving only the most direct official source.

Data analysis proceeded in three linked stages. First, Institutional Voice and Agency Analysis identified how texts distribute authority through passive agency, nominalization, eligibility language, procedural command, and system-dependent terminology. Second, Patient Comprehension Risk Matrix assessed textual features that may create confusion, including acronyms, compressed sequencing, hidden prerequisites, and unclear consequences. Third, Trust-Repair and Accountability Mapping examined whether texts provide transparency, assistance, complaint channels, cancellation options, or responsibility cues. These stages produced an integrated interpretation of how bureaucratic hospital language organizes access, patient burden, and institutional trust without claiming measured psychological effects.

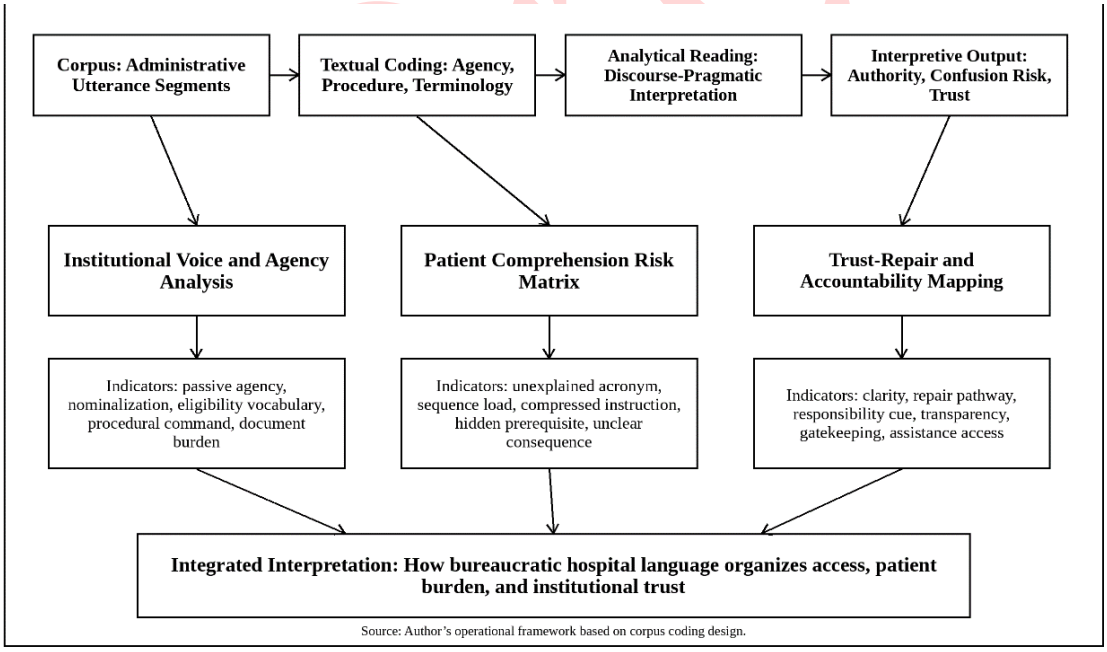


Figure 1. Operational analysis matrix

4. RESULTS

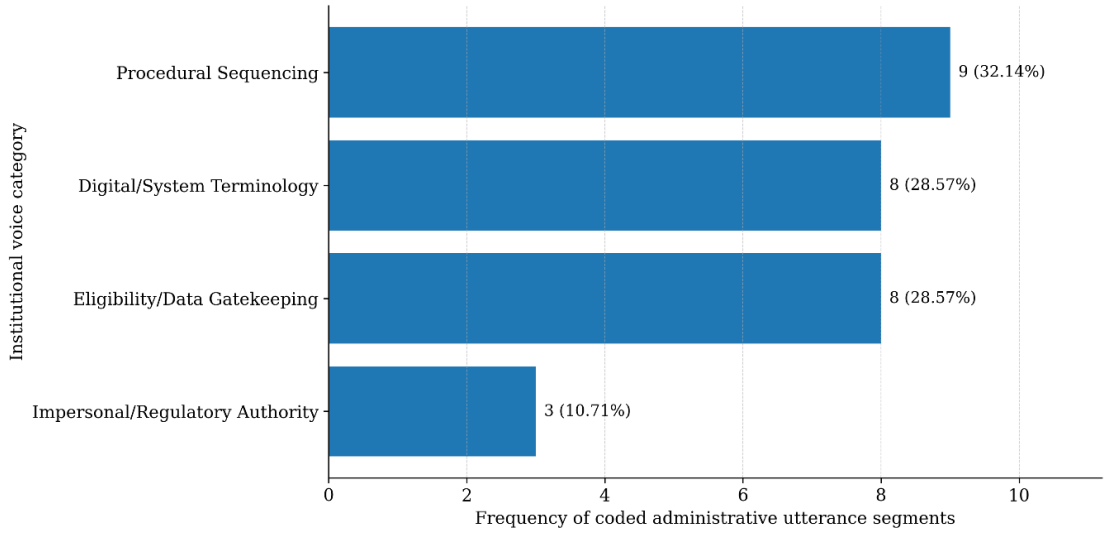
4.1. Bureaucratic voice as procedural authority in healthcare access

Administrative language in this corpus is organized less as conversational guidance than as a procedural architecture through which patients are positioned as users of forms, systems, queues, categories, and institutional rules. The table shows that bureaucratic voice is most visible in procedural sequencing, followed closely by eligibility/data gatekeeping and digital/system terminology. This distribution is consistent with a healthcare environment in which access is increasingly mediated by queue systems, identity verification, BPJS/JKN categories, and platform-based registration. Rather than treating administrative

language as secondary to clinical communication, this pattern shows that patients encounter hospital authority before diagnosis, consultation, or treatment. This aligns with recent studies that connect patient-centred care, administrative procedures, and trust to institutional responsiveness and service intelligibility [11], [12], [14].

Table 2. Distribution of institutional voice in healthcare administrative texts

Main Category	Subcategory	Institutional Indicator	Frequency	Percentage	Data Variation	Example / Corpus Excerpt	Data Code
Procedural sequencing	Registration and service-flow ordering	Stepwise service access through reservation windows, check-in, queueing, registration, clinic visit, pharmacy, cashier, or cancellation status	9	32.14%	Online reservation, outpatient flow, inpatient flow, self-check-in, queue machine, cancellation/reprint menu	"Pendaftaran Online dapat dilakukan untuk kontrol Poli dengan Jadwal H+1 s.d H+30…"; "Pengunjung mengambil nomor antrian; Pasien dipanggil sesuai nomor antrian…"	HBA-PRI-001; HBA-PRI-003; HBA-PRI-004; HBA-PRI-007; HBA-PRI-009; HBA-PRI-011; HBA-PRI-012; HBA-PRI-013
Eligibility and data gatekeeping	Identity, insurance, and document validation	Access depends on patient category, BPJS/JKN status, SEP, NIK/KTP, medical record number, uploaded files, payer type, and demographic completeness	8	28.57%	Self-registration kiosk, new/old patient distinction, BPJS payment selection, inpatient coverage, KTP/NIK alignment	"Jika pasien lama silahkan masukkan No. RM dan tanggal lahir…"; "NIK; No. BPJS… Nama; Tempat Lahir; Tanggal Lahir…"	HBA-PRI-001; HBA-PRI-002; HBA-PRI-004; HBA-PRI-006; HBA-PRI-008; HBA-PRI-011; HBA-SEC-005
Digital and system terminology	Platform-mediated administrative access	Patient action is routed through Mobile JKN, Antroll, Pcare, IHS Number, MPI, API, SATUSEHAT, online registration, or hospital application systems	8	28.57%	BPJS queue apps, FKTP/FKRTL queue, SATUSEHAT identity system, hospital mobile app, electronic registration	"Mobile JKN, FKRTL queue…"; "IHS Number Pasien (NIK Tidak Ditemukan)… MPI… API create patient"	HBA-PRI-005; HBA-PRI-010; HBA-PRI-013; HBA-SEC-001; HBA-SEC-002; HBA-SEC-003; HBA-SEC-004; HBA-SEC-006
Impersonal and regulatory authority	Rule-based institutional command	Authority appears through prohibition, obligation, institutional entitlement, and regulatory mandate rather than interpersonal explanation	3	10.71%	Visitor restriction, SATUSEHAT authority, mandatory RME registration	"Pengunjung yang sedang sakit… tidak diperkenankan…"; "WAJIB mendaftarkan Sistem RME-nya…"	HBA-PRI-008; HBA-SEC-007; HBA-SEC-008



Source: Corpus coding sheet, n = 28 administrative utterance segments.

Figure 2. Distribution of institutional voice in healthcare administrative texts

The dominant pattern is procedural sequencing, representing 9 of 28 coded segments, or 32.14% of the corpus. Its linguistic form is visible in instructions such as "Pendaftaran Online dapat dilakukan untuk kontrol Poli dengan Jadwal H+1 s.d H+30" and service-flow chains such as "Pengunjung mengambil nomor

antrian; Pasien dipanggil sesuai nomor antrian." These excerpts do not simply inform patients; they order patient movement through time, space, and institutional checkpoints. Eligibility/data gatekeeping and digital/system terminology each appear in 8 segments, indicating that administrative access is also shaped by identity fields, insurance status, platform names, and system codes. Phrases such as "No. RM," "NIK," "No. BPJS," "SEP," "Mobile JKN," and "IHS Number" condense institutional requirements into compact technical labels that may be efficient for administration but demanding for patients.

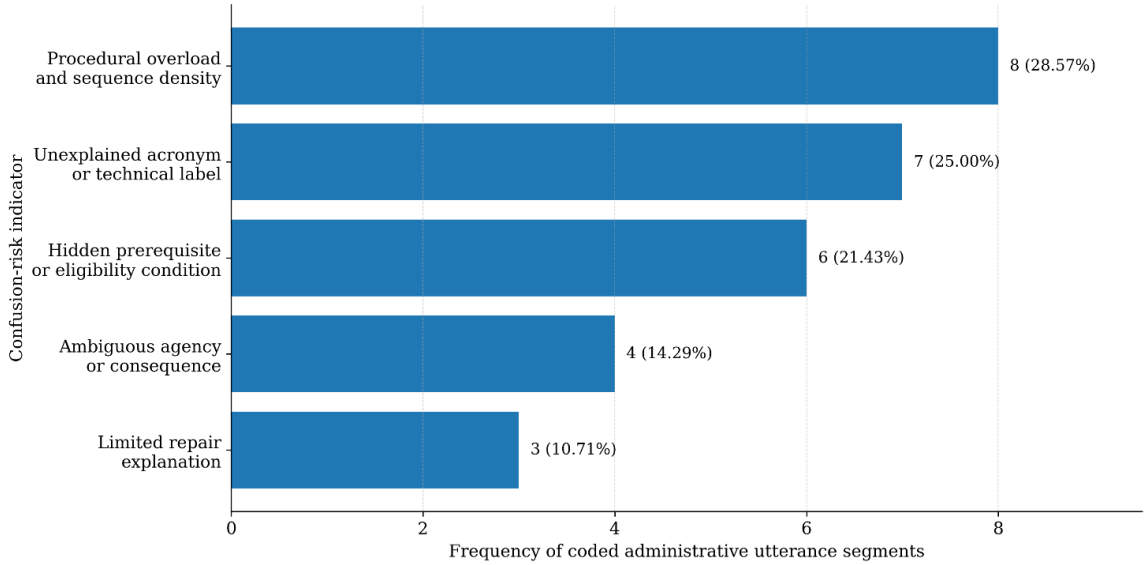
This pattern suggests that bureaucratic voice works through a double movement: it makes hospital access operationally manageable while also transferring interpretive labour to patients. Procedural sequencing tells patients what must be done, but often leaves institutional agency implicit; eligibility language defines who may proceed, but may obscure why certain categories matter; digital terminology connects hospitals to national systems, but may require platform literacy that not all patients possess. This interpretation extends Laila's [4] concern with medical jargon beyond clinical consent and supports Bueter and Jukola's [15] argument that institutional authority can generate epistemic asymmetry in healthcare. In this study, bureaucratic voice is therefore not treated as administrative background. It is analysed as a communicative mechanism through which access, uncertainty, and trust are textually organized.

4.2. Confusion points in registration, verification, and referral pathways

Patient confusion appears most strongly where administrative language requires patients to translate institutional procedure into practical action. The most frequent risk is procedural overload, appearing in 8 of 28 coded segments, followed by unexplained technical abbreviations in 7 segments and hidden prerequisites in 6 segments. These categories remain consistent with the same administrative utterance unit used previously: one complete instruction, requirement, eligibility statement, queue rule, or service explanation. The distribution suggests that confusion is not produced by vocabulary alone, but by the combination of sequence, system, and eligibility. This pattern corresponds with studies showing that patient-centred care requires intelligible participation, not only the availability of information [11], [17].

Table 3. Patient confusion risk across administrative domains

Main Category	Subcategory	Confusion-Risk Indicator	Frequency	Percentage	Administrative Domain	Data Variation	Example / Corpus Excerpt	Data Code
Procedural overload	Sequence density	Multiple actions must be completed in a fixed order before service access becomes possible	8	28.57%	Registration, queue, referral, digital access	Online reservation window, queue number, clinic visit, pharmacy, cashier, check-in, cancellation, reprint menu	"Pendaftaran Online dapat dilakukan untuk kontrol Poli dengan Jadwal H+1 s.d H+30"; "Pengunjung mengambil nomor antrian; Pasien dipanggil sesuai nomor antrian"	HBA-PRI-001; HBA-PRI-003; HBA-PRI-004; HBA-PRI-007; HBA-PRI-009; HBA-PRI-012
Technical abbreviation	Unexplained acronym or institutional label	Access terms are compressed into acronyms or institutional codes without patient-oriented explanation	7	25.00%	BPJS/JKN referral, SEP, medical record, SATUSEHAT identity	No. RM, SEP, NIK, No. BPJS, FKTP, FKRTL, IHS Number, MPI, RME	"NIK; No. BPJS… Nama; Tempat Lahir; Tanggal Lahir"; "IHS Number Pasien (NIK Tidak Ditemukan)"	HBA-PRI-002; HBA-PRI-006; HBA-SEC-003; HBA-SEC-004; HBA-SEC-005; HBA-SEC-008
Hidden prerequisite	Eligibility and document dependency	Patient movement depends on prior status, insurance category, document availability, or system recognition	6	21.43%	Registration, referral, inpatient administration	New/old patient distinction, uploaded files, BPJS payer status, referral validity, KTP/NIK matching	"Jika pasien lama silahkan masukkan No. RM dan tanggal lahir"; "Pilih JKN/BPJS sebagai Cara Bayar"	HBA-PRI-001; HBA-PRI-004; HBA-PRI-006; HBA-PRI-008; HBA-PRI-011
Ambiguous agency	Unclear actor or consequence	Institutional action is stated without clearly naming who verifies, approves, rejects, assists, or resolves the problem	4	14.29%	Verification, regulation, complaint handling	Passive wording, impersonal prohibition, system-mediated validation, institutional obligation	"Pengunjung yang sedang sakit… tidak diperkenankan"; "WAJIB mendaftarkan Sistem RME-nya"	HBA-PRI-008; HBA-SEC-007; HBA-SEC-008
Limited repair explanation	Weak clarification or assistance pathway	Text provides a rule or pathway but gives limited explanation of what patients should do when an error, mismatch, or uncertainty occurs	3	10.71%	Complaint, cancellation, failed verification, data mismatch	Cancellation menu, complaint access, NIK not found, queue reprint, platform error possibility	"Cek/Batal Reservasi"; "IHS Number Pasien (NIK Tidak Ditemukan)"	HBA-PRI-013; HBA-SEC-004; HBA-SEC-006



Source: Corpus coding sheet, n = 28 administrative utterance segments.

Figure 3. Patient confusion risk across administrative domains

The most visible pattern lies in compressed instructions that expect patients to understand procedural timing and institutional categories simultaneously. The phrase "Pendaftaran Online dapat dilakukan untuk kontrol Poli dengan Jadwal H+1 s.d H+30" contains a clear rule, yet it also presumes familiarity with outpatient scheduling logic, the meaning of "kontrol Poli," and the temporal notation H+1/H+30. Similarly, "Pengunjung mengambil nomor antrian; Pasien dipanggil sesuai nomor antrian" appears simple, but it places patient movement inside an ordered institutional rhythm. Abbreviations such as "No. RM," "SEP," "NIK," "No. BPJS," "FKTP," "FKRTL," "IHS Number," and "MPI" intensify this burden because they function as administrative shortcuts rather than explanatory patient guidance.

These patterns show that confusion should be read as an institutional relation rather than a patient deficit. Administrative texts make hospital service governable by standardizing identity, eligibility, referral, queueing, and digital verification; however, this same standardization can obscure agency and reduce interpretive support. Laila's [4] analysis of medical jargon is useful here, but the issue extends beyond clinical terminology into administrative infrastructures. Bueter and Jukola's [15] account of institutional epistemic injustice also helps explain why patients may be positioned as responsible for understanding systems that are not fully translated into patient-centred language. This study therefore treats confusion as a textual effect of bureaucratic organization: access becomes available, but only after patients learn how the institution speaks.

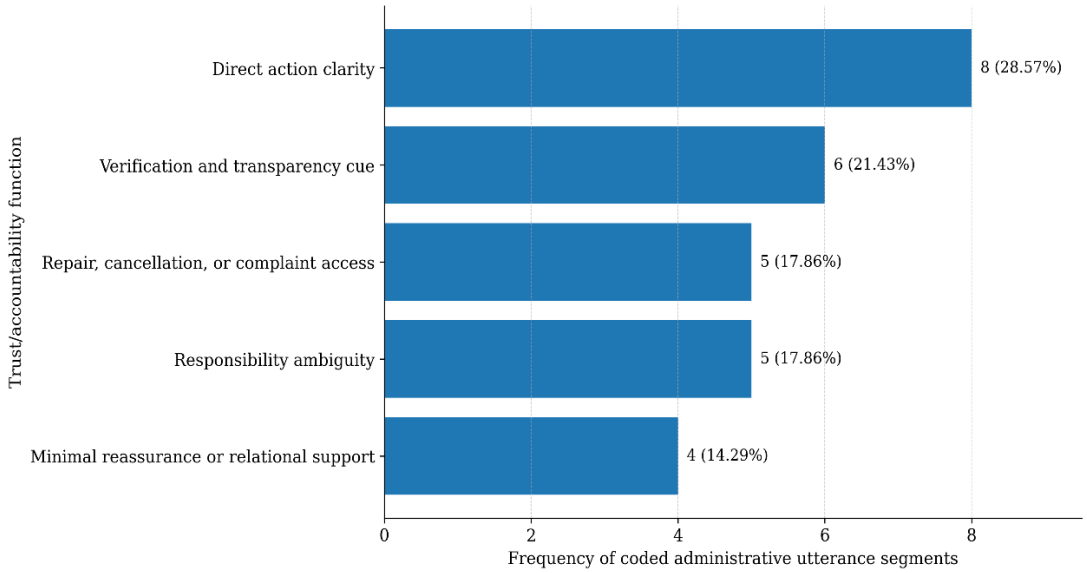
4.3. Trust cues, repair channels, and accountability gaps in administrative texts

Trust in this corpus is produced unevenly through operational clarity rather than through relational reassurance. The most frequent category is direct action clarity, covering 8 of 28 coded administrative utterance segments, followed by verification and transparency cues in 6 segments. This indicates that patient-facing administrative texts often support trust by telling patients what to do and which data or documents are required. However, repair, cancellation, or complaint access appears in only 5 segments, while responsibility ambiguity also appears in 5 segments. The same unit of analysis used in previous findings is retained: one complete administrative instruction, requirement, eligibility statement, queue rule, or service explanation. This consistency shows that trust is embedded in how each administrative segment distributes action, explanation, and responsibility.

Table 4. Trust and accountability functions in healthcare administrative texts

Main Category	Subcategory	Trust / Accountability Indicator	Frequency	Percentage	Administrative Domain	Data Variation	Example / Corpus Excerpt	Data Code
Direct action clarity	Operational guidance	Text gives patients a concrete action to perform, even when explanation remains limited	8	28.57%	Registration, queue, reservation, outpatient service	Online registration, queue number, clinic visit, check-in, service-flow movement	"Pengunjung mengambil nomor antrian"; "Pasien dipanggil sesuai nomor antrian"; "Pendaftaran Online dapat dilakukan…"	HBA-PRI-001; HBA-PRI-003; HBA-PRI-004; HBA-PRI-007;

								HBA-PRI-009
Verification and transparency cue	Identity and service validation	Text makes visible which data, document, number, or platform is used to recognize patient eligibility	6	21.43%	BPJS/JKN, SATUSEHAT, hospital registration	NIK, No. BPJS, No. RM, SEP, IHS Number, patient demographic fields	"NIK; No. BPJS… Nama; Tempat Lahir; Tanggal Lahir"; "IHS Number Pasien…"	HBA-PRI-002; HBA-PRI-006; HBA-SEC-003; HBA-SEC-004; HBA-SEC-005
Repair, cancellation, or complaint access	Administrative correction pathway	Text provides a limited route for patients to cancel, check, reprint, or seek service repair	5	17.86%	Reservation, digital queue, complaint/service assistance	Cek reservasi, batal reservasi, cetak ulang, complaint channel, platform-based checking	"Cek/Batal Reservasi"; "Cek Antrian"; "Cetak SEP"	HBA-PRI-011; HBA-PRI-013; HBA-SEC-001; HBA-SEC-006
Responsibility ambiguity	Weak actor specification	Text states institutional obligation, prohibition, or system requirement without clearly naming who explains, verifies, assists, or resolves uncertainty	5	17.86%	Regulation, verification, inpatient rule, system registration	Passive rule, mandatory registration, visitor restriction, system validation	"Pengunjung yang sedang sakit… tidak diperkenankan"; "WAJIB mendaftarkan Sistem RME-nya"	HBA-PRI-008; HBA-SEC-007; HBA-SEC-008
Minimal reassurance or relational support	Low affective accessibility	Text organizes procedure but rarely provides reassurance, empathy, or patient-centred explanation of why steps matter	4	14.29%	Registration, referral, digital access	Administrative command without relational framing, explanation, or patient support cue	"Pilih JKN/BPJS sebagai Cara Bayar"; "Jika pasien lama silahkan masukkan No. RM dan tanggal lahir"	HBA-PRI-001; HBA-PRI-004; HBA-PRI-006



Source: Corpus coding sheet, n = 28 administrative utterance segments.

Figure 4. Trust and accountability functions in healthcare administrative texts

The dominant textual pattern is pragmatic clarity without sufficient relational support. Instructions such as "Pengunjung mengambil nomor antrian" and "Pasien dipanggil sesuai nomor antrian" make patient movement legible, while "NIK; No. BPJS… Nama; Tempat Lahir; Tanggal Lahir" clarifies the data fields required for recognition. These statements can reduce uncertainty by identifying required actions and institutional identifiers. Yet trust becomes more fragile when explanation stops at operational command. For example, "Cek/Batal Reservasi" provides a repair pathway, but it does not fully explain what happens after cancellation, who verifies the change, or where patients can seek help if the system fails. Similarly, "WAJIB mendaftarkan Sistem RME-nya" signals institutional obligation, but responsibility remains system-centred rather than patient-oriented.

These findings place trust within the textual mechanics of healthcare administration. Groves et al. [12] describe patients' sense of security as something produced through recognizable care actions, while Souvatzi et al. [13] connect healthcare trust to institutional credibility and reliability. In this corpus, credibility is communicated through data visibility, queue order, and procedural instruction, but not always through empathy, explanation, or repairability. This distinction extends Rusita's [7] and Rahman's [24] emphasis on relational safety by showing that administrative texts can be trust-relevant even when they do not use

affective language. This study therefore argues that hospital trust is not only built in clinical encounters; it is also organized through whether administrative language makes responsibility, assistance, and next steps intelligible to patients.

5. DISCUSSION

The predominance of procedural sequencing indicates that healthcare administration functions as an ordering technology: it makes hospital access manageable by transforming patients into actors who must move correctly through reservation windows, queue numbers, eligibility checks, registration desks, clinics, pharmacies, and payment points. Its function is organizational clarity; its dysfunction is that clarity is often addressed to institutional workflow rather than patient understanding. This finding extends Havana et al.'s [11] view that patient-centred care depends on involvement, because involvement cannot begin only at the clinical encounter. It begins when patients first interpret how to enter the system. The corpus therefore shows that hospital communication is not peripheral to care but part of care's administrative infrastructure. Where procedural language is explicit, it may reduce uncertainty; where it is compressed, it can convert access into a test of administrative literacy. This study consequently reframes hospital bureaucracy as a communicative environment that shapes whether patients experience care as navigable or institutionally distant.

This procedural dominance can be explained by the structural logic of contemporary healthcare systems, where hospitals must coordinate high service volume, insurance rules, digital queues, referral pathways, and documentation demands. Such systems require standardization, and standardization tends to produce compressed administrative language. Hussain et al. [14] connect administrative procedures with patient satisfaction and trust, while Gross and Koffman [17] show that communicative clarity is central to serious healthcare decision-making. However, this corpus suggests a tension: what is efficient for coordination may not be equally intelligible for patients. The structure beneath the language is therefore not merely linguistic but organizational. Hospitals speak through rules because they must distribute responsibility across desks, applications, insurers, and databases. Yet this distribution often weakens visible human agency. This finding is consistent with Bueter and Jukola's [15] concern with institutional epistemic injustice: patients are expected to comply with systems whose terms are not always translated into usable knowledge.

The concentration of confusion risk around procedural overload, acronyms, and hidden prerequisites matters because it shifts the problem from individual comprehension to institutional readability. Patients are not simply failing to understand; they are being asked to interpret layered terms such as NIK, SEP, No. RM, BPJS, FKTP, FKRTL, IHS Number, and MPI while also tracking sequence, eligibility, and document validity. This finding supports Laila's [4] work on medical jargon but broadens its relevance beyond informed consent into administrative access. It also resonates with Nurtyas [6] and Anandasari [8], who show that communication breakdowns can intensify when language, symptoms, and institutional procedures intersect. The implication is that patient confusion should be treated as a safety-relevant communicative condition, not as a minor inconvenience. Administrative misunderstanding may not equal clinical harm, but it may delay access, increase dependence on intermediaries, and reduce confidence in the institution's capacity to guide patients.

The underlying structure of this confusion lies in the asymmetry between institutional categorization and patient experience. Hospitals and national health systems classify people through payer type, referral status, identity number, medical record, platform account, and service route; patients, by contrast, approach hospitals through illness, urgency, anxiety, and practical need. This mismatch explains why technically correct texts may still be difficult to use. Escobedo et al. [20] show that limited language access can restrict healthcare participation, while Cipta et al. [16] argue that culturally sensitive healthcare must respond to local behaviour and interpretation. This corpus adds that even within one national language, institutional terminology can create a second language of administration. It differs from studies that locate barriers primarily in multilingualism or clinical explanation, because here the barrier emerges from bureaucratic compression. This means that simplification should not only translate difficult words; it should reorganize sequence, agency, and consequence around patient action.

Trust cues in the corpus are mainly procedural rather than relational: texts build confidence by telling patients what to do, what documents to prepare, which numbers matter, and where certain functions such as checking, printing, or cancellation can occur. This finding partly supports Groves et al. [12], who argue that patients' sense of security is produced through recognizable care actions, and Souvatzi et al. [13], who associate trust with institutional credibility and reliability. Yet it also complicates empathy-centred accounts of healthcare communication. Rusita [7] and Rahman [24] emphasize relational safety, but administrative trust in this corpus often appears without warmth, reassurance, or interpersonal recognition. Its function is predictability; its dysfunction is that predictability can become impersonal when responsibility and repair remain unclear. Trust, therefore, is not only a matter of compassionate wording. It also depends on whether administrative texts make next steps, institutional obligations, and help routes sufficiently visible to patients.

The structure beneath this trust pattern is a service system that defines credibility through compliance, verification, and routinized flow. Hospitals must demonstrate order: queues must be regulated, identities must be validated, referrals must be checked, and electronic systems must be synchronized. These requirements help explain why trust is expressed through numbers, documents, systems, and commands rather than through dialogic explanation. This does not contradict patient-centred care literature; rather, it specifies one of its neglected conditions. Patient-centredness cannot be sustained if administrative language remains system-centred. Jones et al. [25], Kang et al. [26], Suryani et al. [28], and Sirrs [27] show that patient safety and organizational culture depend on communication, accountability, and learning. This study extends that insight to patient-facing bureaucracy: trust is weakened not only by poor clinical interaction but also by administrative texts that fail to show who is responsible, what happens next, and how patients can recover from procedural failure.

6. CONCLUSION

This study concludes that Indonesian healthcare administration speaks through a bureaucratic voice that simultaneously organizes access and burdens patient interpretation. Its most important lesson is that confusion does not emerge only from medical jargon or clinical asymmetry, but also from administrative texts that compress procedures, eligibility categories, digital-system terminology, and institutional responsibility into patient-facing instructions. By treating registration pages, queue rules, referral requirements, identity verification, and repair pathways as linguistic data, this study renews medical-linguistic inquiry beyond doctor–patient interaction. Its contribution lies in connecting institutional discourse, patient comprehension risk, and trust into one methodological framework for analysing healthcare administration as communicative infrastructure.

This study is limited by its reliance on publicly available administrative texts rather than direct observation, patient interviews, comprehension testing, or ethnographic tracking of service encounters. It therefore identifies textual risks and trust cues, but does not measure how different patient groups actually interpret, negotiate, or experience these texts in hospitals. Future research should combine discourse-pragmatic analysis with patient-centred methods, including think-aloud reading, multilingual comprehension assessment, usability testing, and interviews with patients, front-desk staff, nurses, and hospital administrators. Comparative studies across public, private, rural, urban, Islamic-friendly, and digitally integrated hospitals would also clarify how bureaucratic voice varies across institutional settings.

ACKNOWLEDGMENTS

The author thanks the reviewers and editorial team for their constructive feedback on this manuscript.

FUNDING INFORMATION

Author states no funding involved.

AUTHOR CONTRIBUTIONS STATEMENT

Ivan Riyadi: conceptualization, methodology, formal analysis, writing – original draft, writing – review and editing.

CONFLICT OF INTEREST STATEMENT

Author states no conflict of interest.

AI USE DECLARATION

The author used artificial intelligence tools to assist with the generation of illustrative figures and with the formatting and layout of this manuscript. AI was not used to generate the substantive content, conceptualization, data, analysis, or conclusions of the research, all of which remain the sole responsibility of the author.

INFORMED CONSENT

Not applicable – this study did not involve direct human participants. Data consisted solely of publicly accessible administrative texts, registration and service-flow materials, and regulatory-context sources.

ETHICAL APPROVAL

This research did not involve human or animal subjects; it analyzed publicly accessible administrative texts, registration and service-flow materials, and regulatory-context sources, and therefore no institutional review board approval was required. Where research does involve human subjects, the author affirms that such research would be conducted in full compliance with all relevant national regulations and institutional policies, in accordance with the tenets of the Declaration of Helsinki, and would be approved by the author's institutional review board or equivalent committee.

DATA AVAILABILITY

The corpus of publicly accessible administrative texts, registration and service-flow materials, and regulatory-context sources analyzed in this study are available from the corresponding author upon reasonable request.

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