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Research Article

TRANSFORMING HEALTHCARE GOVERNANCE THROUGH LOCAL WISDOM: *JENGAH NGAYAH*-BASED TRADITIONAL HEALTH TOURISM MODEL AT TAMAN USADA BALI

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Abstract
The commodification of Balinese culture in tourism and the systemic dysfunction of modern, mechanistic healthcare governance highlight a critical need for holistic healing alternatives. Although traditional health tourism (*Usada*) in Desa Baru, Tabanan Regency, offers significant potential as an antithesis to this issue, its management remains sub-optimal. This study aims to analyze the existing governance dynamics and design a health tourism governance model rooted in local wisdom. Employing a qualitative approach with a multi-site case study design, data were collected through participatory observation and in-depth interviews with key informants, followed by thematic analysis. The findings reveal that addressing the failure of modern medical institutions to provide equitable and empathetic care requires a fundamental paradigm shift. Consequently, this study formulates the "Integrated Governance Model Based on *Jengah Ngayah*," which adapts the autonomous structure of the *Desa Adat* (customary village) and synthesizes it with the philosophies of *Tri Hita Karana, Taru Pramana,* and *Bayu Pramana*. The novelty of this research lies in redefining the service paradigm from transactional medical interventions to *yadnya* (spiritual devotion), creating a unique hybrid of community-based governance and traditional healing. In conclusion, this model effectively fosters a non-discriminatory, comprehensive healing environment. The practical implications suggest that integrating indigenous spiritual values into tourism governance not only secures a competitive destination advantage but also preserves local cultural authenticity through sustainable holistic healing experiences.

Keywords: Balinese *Usada*, *Jengah Ngayah*, Tourism Governance, Traditional Health Tourism, *Tri Hita Karana*

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INTRODUCTION

Bali is globally renowned as a cultural and spiritual tourism destination, rich in local wisdom, particularly the Balinese Usada healing tradition. This comprehensive traditional medical system balances

the gross and subtle body dimensions (shtula sarira–suksma sarira–antah karana), viewing health as a complete equilibrium of body, mind, and soul (Sukarlinawati, 2023; Fahyan & Farhah, 2024; Suardiana et al., 2025). Deeply rooted in the Tri Hita Karana philosophy, health disorders are perceived as an imbalance in the relationship between humans, God, fellow humans, and the universe (Rasmini, 2022; Fahyan & Farhah, 2024; Johnson, 2025; Suardiana et al., 2025). Combined with Taru Pramana (medicinal plants) and Bayu Pramana (energy and breath regulation), this approach utilizes rituals, mantras, and sacred scripts to invoke life energy and absorb magico-religious energy for the patient's recovery (Suweta, 2021; Suardiana et al., 2025). This is reinforced by the concept of Dasa Bayu, linking sacred scripts to the ten life energies operating within the human body's organs (Suweta, 2021).

However, this holistic service philosophy sharply contrasts with the reality of modern healthcare industry governance today. Modern medical systems often suffer from systemic dysfunction, focusing solely on procedural efficiency, rigid bureaucratic standardization, and cold clinical handling. This excessive focus on technical-mechanical aspects directly affects the neglect of humanistic and empathetic aspects, triggering high rates of complaints and patient dissatisfaction. Consequently, the dynamic between medical personnel and patients is reduced to merely an impersonal "transactional-mechanical" relationship, where patients often feel alienated, ignored, or experience service discrimination due to social status stratification (Parma et al., 2020; Arida et al., 2025; Rai & Dyah, 2025).

To bridge the shortcomings of this modern service bureaucracy, Taman Usada Bali in Desa Baru, Marga District, Tabanan Regency, was established in 2020 as a center for therapy, education, and cultural preservation. Yet, its governance faces significant practical challenges. Tourists' understanding of wellness is still narrow and often reduced to mere body care or conventional spa services, rather than culturally-based holistic healing (Susanti, 2022; Mananda & Kristanto, 2023; Rai & Dyah, 2025). In fact, the spa and wellness sector in Bali has grown rapidly by over 160% since 2003 with the presence of around 390 spa units (Susanti, 2022; Mananda & Kristanto, 2023; Rai & Dyah, 2025). Various studies confirm that Bali's greatest wellness potential actually lies in the integration of nature, spirituality, usada, melukat, and herbal medicine, but unfortunately, this potential has not yet been integrated and strongly branded as a distinct type of wellness (Parma et al., 2020; Susanti, 2022; Dewi, 2025; Rai & Dyah, 2025). Moreover, both nationally and regionally, the development of wellness tourism is still hindered by regulatory barriers, inter-agency coordination, and the availability of integrated data (Parma et al., 2020; Arida et al., 2025; Rai & Dyah, 2025).

Despite the recognized potential of traditional wellness, a significant research gap remains in the literature. Previous studies have discussed how the implementation of the values of *Menyama-Braya*, *Tat Twam Asi*, and *Tri Hita Karana* can support social harmony and sustainable community-based tourism (Dolezal & Novelli, 2020; Mulyana, 2025). Recent studies also indicate that pentahelix models will be most effective in strengthening cultural tourism villages if actor synergy is built upon local wisdom (Rakhman & Rochman, 2023; Diwyarthi et al., 2025). However, existing literature has not yet formulated a specific, integrated governance model that operationalizes indigenous philosophies to explicitly counter the mechanical failures of modern healthcare.

Addressing this gap is the primary rationale for this study. Reconstructing an alternative governance model deeply embedded in local ethics offers an ideal solution. By adopting the *Desa Adat* leadership (*prajuru*) structure, healthcare management can reflect a philosophy of harmonious living. The value of *Jengah* (internal motivational spirit for self-improvement) combined with *Ngayah* (selfless service) creates a governance foundation based on participation and social responsibility. The principles of good governance, which include participation, transparency, and equitable distribution of benefits, show significantly improved performance when combined with local values and strong customary institutions (Raharja & Mahyuni, 2021; Kumalasari et al., 2025; Nabuasa et al., 2025; Rama et al., 2025; Winston et al., 2025).

Therefore, this study aims to analyze the current dynamics of health tourism governance and design a novel model rooted in Balinese wisdom. To achieve this objective, the research addresses the following research questions: (1) What are the current governance dynamics and challenges faced by traditional health tourism in Desa Baru? and (2) How can the "Integrated Governance Model Based on *Jengah Ngayah*" be formulated and implemented to enhance destination competitiveness while preserving the authenticity of Balinese culture amid the failures of modern health governance?.

RESEARCH METHOD

This study uses a qualitative approach with a multi-site case study design to deeply explore the contrasts, dysfunctions, and potential integration between modern and traditional health governance. The selection of this case study method aligns with research precedents in Ubud and Thailand, which consistently rely on field observations, in-depth interviews, and thematic analysis to explore community participation and the dynamics of local wisdom in the wellness industry (Hubner et al., 2025; Rahjasa & Naur, 2024; Thojampa et al., 2023). To clarify the sampling method, the determination of the research locations and informants was carried out deliberately using purposive sampling based on specific criteria. The locations were divided into two contrasting clusters representing the dichotomy of the healthcare service system: the first cluster includes several General Hospitals (RSU) as a representation of modern health industry governance that tends to be rigid and clinically-procedurally oriented; the second cluster is Taman Usada Bali in Desa Baru, Marga District, Tabanan Regency, representing a destination that has integrated traditional healing (*Usadha*) into professional governance management since 2020.

The primary data were collected comprehensively through intensive participatory observation of the empirical service flow, semi-structured in-depth interviews, and document studies. Data collection was guided by a qualitative instrument grid encompassing key themes: bureaucratic structures, service philosophies, implementation of local wisdom, and service dysfunctions. The purposive selection of informants was based on the principles of suitability and adequacy regarding direct involvement in the development of traditional health tourism. Specifically, the 10 key informants consisted of: 1 owner/manager of Taman Usada Bali, 2 representatives from the Tabanan Regency Health Office, 1 representative from the Tabanan Regency Tourism Office, 2 practitioners and experts in Balinese traditional therapy, 2 international tourists with experience participating in wellness and traditional therapy programs, 1 customary leader of Desa Baru, and 1 official from Desa Baru. Because this research is qualitative, quantitative parameters such as statistical power based on sample size are not applicable. Instead, the "power" and validity of the study (trustworthiness) were strictly maintained through source triangulation, method triangulation, and member checking with key informants until data collection reached the point of theoretical saturation.

The primary data collection focused on identifying the crystallization of cultural values shaping work ethics based on *Jengah Ngayah*, while secondary data were obtained through documentation studies of hospital Standard Operating Procedures (SOPs), national health regulations, regional tourism policies, and scientific literature on Balinese local wisdom. Regarding the analysis strategy, because this is a qualitative inquiry, statistical analysis tools (such as SmartPLS or Amos) and quantitative variable measurements were not employed. Instead, all data from both clusters were analyzed using an interactive thematic analysis approach consisting of data condensation/reduction, data categorization (coding), and data presentation/display to draw verifiable conclusions. This process identified patterns of modern service dysfunction and conceptualized the internalization of *Jengah Ngayah* and *Tri Pramana* values. The problem-solving approach is directed towards developing a Value-Based Governance Model that integrates managerial functions with local spirituality, supported by digitalization, market diversification, human resource competencies, and pentahelix partnerships.

RESULTS AND DISCUSSION

Dysfunction of Transactional Services: The Reality of Modern Health Governance Failures

The development of the modern healthcare industry is often caught up in the demands of operational efficiency and achieving metric targets, which gradually erodes the fundamental essence of Patient-Centered Care. Governance failures in delivering this ideal service have been empirically proven through field observations, where crises of empathy and discrimination in social security services still frequently occur. As a result, hospital institutions today tend to be reduced to mechanical “healing factories’. This systemic dysfunction is clearly seen in slow bureaucratic responsiveness, unequal clinical guarantees, and the commodification of empathy that heavily depends on the financial class of the patient.

The first governance failure manifested in the loss of a sense of urgency and systemic responsiveness, particularly in handling emergencies. At primary-level hospital facilities, the patient examination flow from the ER to the laboratory or radiology takes up to two to three hours to complete. Patients even have to endure a waiting time of around seven hours, counted from entering the ER at 1:00 PM until being sent off with a referral ambulance at 8:00 PM. This bureaucratic sluggishness continues at the referral hospital, where patients who arrive at the ER at 9:00 to 10:00 PM are only executed for

surgical procedures at 8:00 AM. Ironically, the management of clinical communication during that waiting period was very poor; the ER nurses did not provide transparency regarding the surgery queue and repeatedly gave normative promises at 11:00 PM, 2:00 AM, and 4:00 AM that the patient "would be operated on soon." This failure in responsiveness also occurred in the outpatient line (BPJS Clinic), where the online registration innovation at the beginning of the process proved ineffective in preventing service bottlenecks, as seen from the very long queues at the pharmacy when collecting medication.

In addition to response dysfunction, managerial governance also fails to provide assurance of competence and fair safety for all patients. In the initial trauma management phase, invasive actions such as suturing severely torn skin are carried out by nurses instead of surgeons, while the on-duty doctors, who are residents, also appear to be not independent and slow to coordinate with senior doctors without adequate supervision. Similar gaps in clinical assurance recur in outpatient services, where medical observation is mostly dominated by resident doctors and medical interns, while senior specialist doctors are rarely seen and only make brief visits. This management failure creates a sharp irony when compared with the dimension of physical facilities (tangibles). On one hand, primary hospitals fail to provide comprehensive services because they lack the necessary medical equipment for fracture and severe wound cases, which triggers a referral chain. On the other hand, referral hospitals have proven to be physically competent, with post-operative sterile skin surgery rooms without visiting hours, as well as comfortable and clean outpatient facilities. However, the management of these luxurious facilities has proven to be non-inclusive, marked by the absence of mobility assistance staff (such as porters) for patients with leg injuries in the clinic, as well as the rigid implementation of BPJS procedures, which require patients with severe post-trauma to go directly, moving from Facility 1 to Facility 2 just to handle referrals for administrative validation. This condition is in line with JKN studies showing that clinical quality at referral hospitals can be good, but patient experience is actually burdened by complicated administrative processes and long waiting times (Alfarizi et al., 2024; Rahmannisa et al., 2025).

The most fundamental evidence of the failure of modern healthcare industry governance is the humanitarian crisis in the form of the commodification of empathy and discriminatory treatment. Services fail to provide basic empathy regarding pain management, as evidenced when patients scream in excruciating pain during wound suturing because the local anesthetic administered is inadequate to suppress the pain on severely peeled skin. This empathy crisis worsens into transactional discrimination in referral hospitals. When under BPJS patient status in the emergency room, nurses and doctors are indifferent, unfriendly, and provide only minimal clinical information. Conversely, when the patient's funding status changes to VIP inpatient and social capital (connections with senior doctors) is used, service guarantees increase sharply; doctors are willing to engage in detailed discussions and conduct daily bedside visits with the full team. Not only that, the nurses in the VIP room showed excessive empathy, were very friendly, always smiling, paid close attention to complaints, and were even willing to escort patients to the parking lot upon leaving. This phenomenon of discrimination aligns with findings in low-income Medicaid patients who reported that socioeconomic status (SES) affects treatment, access, and interactions with clinicians, including feelings of being belittled and not listened to (Visconti & Martiniello, 2019).

The conclusions drawn from the compilation of interview and field facts confirm that clinically, technical reliability (such as the success of bone fracture surgery and skin treatment) can indeed be achieved by medical institutions. However, the governance of its services absolutely fails to reach the ideal standard because the quality of care, empathy, and certainty of action are no longer distributed based on the patient's "medical needs," but rather subject to "financial class" and social status. Literature on the "moral market" and health theology (Altomonte & Brown, 2025; Ungar-Sargon, 2025a, 2025b) explicitly highlights this phenomenon, showing that commodification and profitization have eroded the relational meaning of healing and turned clinical encounters merely into financial transactions. Therefore, given that the current system operates purely in a transactional-mechanical manner, this condition demands a radical restructuring that adopts an alternative model in the form of a care economy oriented towards justice, relationships, and responsibility. This restructuring is crucial to restore moral integrity and the principles of Patient-Centered Care throughout the hospital service pyramid, not merely to pursue procedural volume.

Ultimately, healthcare must not be reduced to an industrial production line; it is a fundamental humanitarian endeavor. The true measure of a hospital's excellence should not be calculated solely by its operational speed, procedural volume, or the luxury of its VIP suites, but rather by how it treats its most vulnerable patients. To reclaim its moral compass, the medical industry must recognize that genuine

healing requires far more than sterile rooms and technically successful surgeries. It requires presence, dignity, and unwavering empathy, distributed equally regardless of a patient's socioeconomic standing. Only by dismantling these deeply ingrained discriminatory practices and embracing a true care economy can we build a healthcare system that honors the sanctity of human life and restores the true meaning of Patient-Centered Care.

Antithesis of Modern Services: Traditional Village Institutions and the Spirit of *Jengah Ngayah* in Health Tourism

As an antithesis to the failures of modern healthcare bureaucracy, which tends to be rigid and mechanical, this study offers an alternative governance system rooted in the sociological foundations of Balinese society. This institutional reconstruction is realized by adapting the autonomous structure of the *Desa Adat* into the operations of traditional health/wellness tourism, with the research locus focused on *Usada* Bali practices in Desa Baru, Marga District, Tabanan Regency, Bali. Based on the document "Understanding and Function of *Desa Adat*", this entity is recognized as an autonomous territorial community managed by a prajuru (administrative) structure, such as *Bandesa Adat*, *Penyarikan*, *Petengan*, and *Sinoman*. The main strength of this system lies in the deeply rooted tradition of mutual cooperation, where members of the banjar voluntarily provide selfless assistance to residents who fall ill. This communal characteristic aligns with literature findings which affirm that a sense of attachment, mutual cooperation, and customary task force networks are very effective for crisis management and ensuring social solidarity (Amalia et al., 2023). In the context of village-based wellness tourism, the integration of local wisdom, medicinal plants, and community participation has been shown to strengthen sustainability, local economic justice, and cultural protection (Brooks et al., 2023; Hardyanti & Anggara, 2025; Hubner et al., 2025; Wirawan, 2025). This statement is reinforced by the account of the Traditional Leader of Desa Baru who affirmed, "The involvement of the customary village ensures the sustainability and authenticity of Balinese healing traditions." The implementation of these values of solidarity and cultural protection is strongly confirmed through field observation results in Desa Baru in the tangible dimension (physical evidence). The traditional healing ecosystem is designed to be located in rural areas integrated with nature, equipped with prayer areas and communal spaces. This modest physical environment effectively removes the impression of rigid transactions and creates a soothing holistic healing atmosphere. Conceptually, the embodiment of this spatial arrangement aligns with the implementation of Taman Usada Bali, which divides its area according to the *Tri Mandala* concept, serving as the center for the conservation of Lontar Taru Pramana botany as well as a retreat area to harmonize the body, mind, and soul.

The characteristics of this empathetic communal governance essentially offer a very ideal concept if replicated within the health tourism industry ecosystem. Until now, modern hospitals have often been trapped in impersonal service systems. However, by adopting the protective and familial bond functions typical of village krama (residents), the rigid nature of these medical facilities can be deconstructed. Through a village leadership-style approach, patients are no longer reduced to their status as 'consumers' or mere statistics, but are positioned humanely as 'residents' themselves. This paradigm shift is directly felt by patients, as expressed by one International Tourist: 'I feel more at ease because I am treated as family, not as a patient'. Empirical support for this is clearly seen in the responsiveness dimension in the field, where when patients arrive, medical practitioners (*Jero Mangku*) proactively welcome them and invite them to sit first in the communal area. While the *Jero Mangku* prepares and changes into traditional Balinese attire as a form of spiritual readiness and ethics in serving the community, patients are served snacks and warm drinks such as tea or coffee in the area. The readiness to spend time interacting casually and providing this inclusive initial service has proven to be very crucial in reducing patients' anxiety levels, as well as building mental preparedness before entering the physical recovery phase. The importance of initial reception facilities and a friendly communal environment aligns with research findings in Ethiopia and China, which show that environmental aspects (such as comfortable waiting rooms, fresh air, and geographical proximity) greatly determine perceptions of responsiveness and overall patient satisfaction (Negash et al., 2022; Tang et al., 2023; Zhou et al., 2024).

Furthermore, to curb the commercial nature that often becomes a source of patient dissatisfaction in the modern era, the operations of this healthcare institution must always be imbued with strong moral standards. As a solution, this model proposes the injection of the *Jengah Ngayah* philosophy to be used as a cultural Standard Operating Procedure (SOP) as well as the spirit of service for all healthcare personnel. This philosophy rests on the pillars of jengah (a motivational drive and strong determination

to develop a health tourism ecosystem in Desa Baru, Marga District) and ngayah (the principle of sincere service without expecting financial compensation). This is strongly reflected in the statement of a Balinese *Usada* Practitioner who said, "*Ngayah* is the basis of our service, so healing is not solely economically oriented." The validation of the success of this concept is evident from observations in the dimensions of assurance and reliability. Treatments carried out purely based on the concept of ngayah without charging fees actually generate a very high level of trust from patients. The absence of economic motives provides a moral assurance that patients are truly treated with pure intentions. This aligns with the literature on altruistic motivation patterns (Sertan et al., 2023; Shie et al., 2022; Widiastuti et al., 2024), which asserts that when economic motives are set aside and replaced by moral-spiritual commitment through ethos such as *ngayah*, patients tend to interpret the service as sincere and trustworthy. Ultimately, service reliability is no longer measured solely by medical equipment standards, but by the consistency of spiritual stages that pray for smoothness from *Ida Sang Hyang Widhi* to provide inner peace for the patients.

The integration of the *Jengah Ngayah* philosophy is believed to create a fundamental behavioral transformation, escalating the principles of Servant Leadership to its highest spiritual level. The act of caring for patients undergoes a redefinition of meaning; it is no longer seen merely as a managerial-professional obligation (job), but rather transforms into yadnya (sacred offering) to God through service to others. This transformation aligns with literature findings that indicate that, on the health workers' side, the application of strong spirituality and servant leadership can enhance passion and altruism, so that caring for others is perceived as a source of meaning and inner satisfaction, not just a workload (Demeke et al., 2025; Hamzaa et al., 2025; Maglione & Neville, 2021). However, the perfection of *yadnya* service requires an ecosystem free from discriminatory practices resulting from social stratification (such as differences between VIP patients and social insurance patients). Therefore, this governance also integrates the philosophy of *Menyama Braya*, a concept of egalitarianism and universal brotherhood in Balinese society that views every individual as equal regardless of their economic background or caste. This is evidenced by observational data on the dimension of empathy, where services provided with friendliness, sincerity, and personal attention are able to transcend the rigid boundaries between service providers and patients. This genuine human touch ultimately prevents psychological complaints arising from the neglect of dignity, while simultaneously fostering profound gratitude and emotional recovery.

Nevertheless, equal treatment and a sense of brotherhood cannot be authentically established without being based on inner sensitivity. Considering that the empathy crisis often becomes the main root of dysfunction in modern healthcare governance, medical responsiveness that relies solely on compliance with formal SOPs is certainly not enough. Such responsiveness must be grounded in ontological and spiritual awareness, which within the framework of local wisdom is represented through the teaching of *Tat Twam Asi* ("I am You, and You are Me"). This teaching provides a crucial psychological foundation for the development of effective therapeutic communication. If a healthcare worker is able to feel the patient's suffering as if it were their own, then that care will naturally arise without the threat of managerial sanctions. Such ontological awareness is very much in line with studies on the doctor-patient relationship that represent the ideal concept of "moral beauty", where clinical knowledge must be integrated with an ethical and spiritual calling to accompany the suffering of patients as fellow human beings, rather than merely making them objects of procedures (Rakoczy et al., 2025). As the pinnacle, the combination of structural communal governance and cultural philosophy ensures the presence of a holistic personal touch, a fundamental healing element that guarantees patients achieve full recovery, making it an excellent and authentic model of wellness tourism governance.

Based on the research that has been conducted, the fundamental differences in service quality and governance between conventional medical facilities and traditional healing centers can be clearly observed. The field findings regarding the governance dichotomy and service characteristics between modern hospitals and Taman Usada Bali are comprehensively synthesized in **Table 1** below. This table highlights key dimensions such as responsiveness, empathy, assurance, governance structure, and the nature of patient relationships.

Table 1. Comparison of Service Quality Characteristics and Governance of Modern Hospitals with Taman Usada

Aspect	Modern Hospital	Taman Usada
Responsiveness	Low	High

Empathy	Varied	High
Assurance	Clinical	Clinical-Spiritual
Governance	Bureaucratic	Communal
Patient Relationship	Transactional	Familial

As detailed in Table 1, the comparison vividly illustrates that while modern hospitals lean towards a bureaucratic and transactional model with varying empathy, Taman Usada Bali excels through its communal approach. The high levels of responsiveness and empathy in Taman Usada are directly attributed to its familial patient relationships and integrated clinical-spiritual assurance. This stark contrast underscores the necessity for modern healthcare systems to consider adopting more humanistic paradigms.

The transformation of human resources through the internalization of cultural values will not be optimally realized without the support of a coherent spatial and managerial ecosystem. Therefore, the operational design of this health tourism destination integrates the philosophy of *Tri Hita Karana* balance to create a holistic healing environment. In the context of the health tourism industry, this philosophy is translated into three sustainable service pillars. The first pillar, *Pawongan* (harmony among humans), is realized through interactions between medical staff and patients that are equal, inclusive, and family-oriented to break down barriers of social status discrimination, such as the dichotomy between social insurance (BPJS) services and general patients. The second pillar, *Palemahan* (harmony between humans and nature), demands a redefinition of spatial configuration where health facilities are no longer designed as cramped concrete structures, but rather adopt a rural-inspired architecture that blends organically with the agrarian landscape of Desa Baru, Marga District. Meanwhile, the third pillar, *Parhyangan* (harmony between humans and the Creator), is implemented by accommodating spiritual needs amidst medical interventions, such as providing spaces for inner peace, meditation areas, and full integration with traditional Balinese medicine practices (*Usada*). Through the synergy of these three pillars, the healing operation expands holistically to touch the unity of body, mind, and soul, whose empirical manifestation can be reflected through the blueprint for the development of Taman Usada Bali. This area is designed as a form of manifestation and preservation of *Lontar Taru Pramana* (ancient manuscripts containing traditional plant-based medicinal knowledge) so that this local wisdom does not merely exist as written text, but is implemented in reality as a conservation and holistic healing area. Conceptually, the Bali Usada Garden model offers integrated facilities that function as a conservation and educational center for visitors to learn to recognize, plant, maintain, and process medicinal plants. More than just a botanical tourism destination, this area is designed as a retreat center through healing programs that combine the local wisdom of *Taru Pramana*, *Usada Bali*, and *Ayurveda*, supported by yoga, meditation facilities, and healthy dining options. The landscape development is specifically divided into three components (*Tri Mandala*) focusing on the alignment of body, mind, and soul, with physical implementation including the preservation of medicinal plants, meditation centers, and therapy areas. The ultimate goal of this design is to ensure that every visitor not only takes home botanical knowledge but also gains complete physical and spiritual health recovery, making it an essential reference for the development of wellness tourism and ecotourism integrated with the preservation of the environment and local *Nusantara* culture.

Cumulatively, the integration of the institutional structure of the Customary Village along with the compilation of philosophical values *Jengah Ngayah*, *Menyama Braya*, *Tat Twam Asi*, and *Tri Hita Karana* culminates in a fundamental transformation of the final health tourism product. If implemented consistently in Desa Baru, this governance model will redefine the experiential value received by both tourists and patients. Based on the projections of this governance design, services in the field will present an empirical manifestation in the form of humanistic reception, where tourists no longer go through the bureaucratic registration desk typical of rigid hospitals but are welcomed warmly and personally like honored guests in a village community hall. The healing process is then carried out in a natural therapy room, a spatial ecosystem directly integrated with the lush rural nature of Marga, thus freeing patients from exposure to clinical or chemical medicine odors typical of conventional medical facilities. This comprehensive approach culminates in the creation of a zero-complaint service. The potential for complaints can be significantly minimized, considering that every service interaction is based on smiles, genuine friendliness, and boundless patience derived from the spirit of sincere devotion (*Ngayah*).

From the perspective of services marketing theory and health tourism, the preferences of today's global tourists have undergone a fundamental evolution. They are no longer merely seeking 'clinical cure' for a disease, but specifically long for a complete 'healing experience.' This holistic governance model

automatically creates a sustained competitive advantage, an exclusive foundation that cannot be replicated solely by the sophistication of modern hospital technology. By exceeding the emotional and spiritual expectations of tourists, Taman Usada Bali in Desa Baru, Marga, is projected not only to operate as an alternative medicine clinic, but also to be ready to transform into an epicenter and a role model for premium traditional health tourism at both the national and global levels.

The primary novelty of this research lies in the theoretical and practical hybridization of the *Desa Adat* (customary village) autonomous governance structure with the profound Balinese philosophies of *Jengah Ngayah* and *Menyama Braya*, applied specifically within the context of modern wellness tourism management. While previous studies have examined *Usada* (traditional medicine) from a clinical or botanical perspective, this study pioneers the conceptualization of traditional community ethos as a formal Standard Operating Procedure (SOP) for health tourism services, positioning local wisdom not just as a cultural attraction, but as the core organizational behavior. Theoretically, this study implies an expansion of the Services Marketing and Servant Leadership paradigms by proving that spiritual and communal altruism (non-economic motives) can significantly elevate patient trust and service reliability, particularly in the assurance and empathy dimensions. Practically, the Taman Usada model provides a tangible blueprint for destination managers and local governments to construct zero-complaint, holistic health tourism ecosystems that consistently protect both patient dignity and cultural heritage. Nevertheless, this study has limitations as it is bounded by its specific geographical and cultural locus in Desa Baru, Marga District, Bali. This implies that the strong presence of *Desa Adat* structures and specific Hindu-Balinese philosophies may limit the direct replicability of this exact model to regions with vastly different socio-cultural landscapes, coupled with the fact that the evaluation of service quality still relies heavily on qualitative patient perceptions and observational data that are prone to subjective biases. As a recommendation for future research, it is suggested to conduct quantitative or mixed-method studies to statistically measure the impact of this communal governance model on patient recovery rates and long-term satisfaction across various traditional healing centers. Meanwhile, for policymakers and practitioners, it is highly recommended to officially integrate customary village institutions into the regulatory framework of regional health tourism to ensure that local communities are empowered as primary stakeholders, rather than mere objects of the tourism industry.

CONCLUSION

This research concludes that the governance of the modern healthcare industry is currently experiencing systemic dysfunction caused by the domination of bureaucracy and clinical mechanization. The rigid transactional relationship patterns within this system have been proven to alienate patients, trigger an empathy crisis, and create service discrimination based on financial class. As a strategic solution to these issues, this study offers a novelty in the form of a Traditional Health Tourism Governance Model based on the *Jengah Ngayah* Value, which is synergistically integrated with the autonomous institutions of Customary Villages and spatial planning based on the *Tri Hita Karana* philosophy. This governance model is based on the fundamental assumption that the quality of the healing experience is not only determined by medical technical competence but also heavily depends on the quality of social relations, service spirituality, and the level of trust that is built. By integrating Governance Theory, Collaborative Governance, Community-Based Tourism Governance, Value-Based Governance, and Servant Leadership, this study formulates a comprehensive theoretical chain of traditional health tourism governance. The conceptual flow begins with the value of *Jengah Ngayah*, which serves as the philosophical foundation and source of local cultural values to trigger awareness of sincere service. These cultural values then shape the character of Servant Leadership, manifested as leadership that serves, where healthcare personnel are always oriented towards dedication (*yadnya*). This leadership then transforms into Service Quality & Empathy, namely, excellent service quality driven by deep empathy and sensitivity to patients' suffering. Such empathetic service quality automatically produces Patient Trust, which is the absolute trust of patients in the competence, integrity, and sincerity of service providers. This trust, in turn, becomes a crucial foundation for the creation of a Healing Experience in the form of a holistic, complete healing experience encompassing physical, emotional, social, spiritual, and cultural aspects. At its peak, the accumulation of authentic healing experiences culminates in Destination Competitiveness, which creates sustainable competitive advantages for the destination.

Practically, the implementation of this model radically transforms the healthcare service paradigm from merely a medical-commercial intervention into a form of spiritual devotion. Through the adoption of the village *prajuru* system, patients are positioned like their own family (*krama desa*) who are entitled to equal and non-discriminatory care. Operational synergy through the pillars of *Pawongan* (empathetic interaction), *Palemahan* (architecture with an agrarian nature ambiance), and *Parhyangan* (inner peace through *Usada* practice) has been conceptually proven to create a comprehensive healing ecosystem. The service orientation is no longer solely focused on 'clinical recovery', but extends to the maximization of the patient's emotional restoration. This creates a competitive advantage that is impossible to replicate by modern medical facilities, while also establishing Taman Usada Bali in Desa Baru as a role model for traditional health tourism destinations. Theoretically, this study makes a significant contribution to filling the gap in literature related to the management of traditional health tourism by synthesizing the concepts of governance and Servant Leadership through a local wisdom (indigenous knowledge) approach. Furthermore, the policy implications of this research strongly urge policymakers to formulate integrative regulations that formally recognize and protect traditional health tourism frameworks, ensuring that future standardizations empower local customary institutions.

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AUTHOR CONTRIBUTIONS

Conceptualization: Semara, I.M.T., Nandaka, I.K.T., & Yadnya, I.B.P.; Methodology: Semara, I.M.T.; Software: Semara, I.M.T.; Validation: Semara, I.M.T., Nandaka, I.K.T., & Yadnya, I.B.P.; Formal Analysis: Semara, I.M.T.; Investigation: Semara, I.M.T.; Resources: Semara, I.M.T.; Data Curation: Semara, I.M.T.; Writing – Original Draft Preparation: Semara, I.M.T.; Writing – Review & Editing: Nandaka, I.K.T. & Yadnya, I.B.P.; Visualization: Semara, I.M.T.; Supervision: Nandaka, I.K.T. & Yadnya, I.B.P.; Project Administration: Nandaka, I.K.T. & Yadnya, I.B.P.; Funding Acquisition: Semara, I.M.T.

CONFLICTS OF INTEREST

The author(s) declare no conflict of interest.

USE OF ARTIFICIAL INTELLIGENCE (AI)-ASSISTED TECHNOLOGY

The authors declare that no artificial intelligence (AI) tools were used in the generation, analysis, or writing of this manuscript. All aspects of the research, including data collection, interpretation, and manuscript preparation, were carried out entirely by the authors without the assistance of AI-based technologies.

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