Patients' Satisfaction in Public and Private Primary Health Care: A Study in Karawang Regency, West Java, Indonesia

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Abstract

Background: Primary health care is the foundation of the Sustainable Development Goals (SDGs) to achieve Universal Health Coverage (UHC). Patient satisfaction with the health services acquired is one of the factors to achieve the UHC target. This study aimed to determine patients' satisfaction in public and private primary health care centers.

Methods: This quantitative analytic study with a cross-sectional method was conducted in five sub-districts of Karawang Regency based on community satisfaction surveys. The instrument used was a standard questionnaire with nine dimensions and filled with a survey approach by the respondents. Data was transformed from ordinal to numeric using Rach modelling. Then, numerical data were analysed with Chi Square Test in IBM SPSS Statistic 23 Version to determine differential between public and private groups.

Results: In total, 193 respondents were included of whom 123 patients were from public health centers (Pusat Kesehatan Masyarakat, Puskesmas) and 70 from private primary care (clinic). Three dimensions had differences in satisfaction, including the requirements (p=0.001); systems, mechanisms, and procedures (p=0.001); and service time (p=0.001). The other six dimensions such as cost (p=0.534); product specification type of service (p=0.213); implementer competence (p=0.163); implementer behavior (p=0.000); handling of complaints, suggestions, and advances (p=0.448); and facilities infrastructure (p=0.063) were not proven to have differences in satisfaction. Overall, patients' satisfaction level at Puskesmas (67.5%) was lower than at clinics (88.6%) (p=0.001).

Conclusion: Patients' satisfaction with the Puskesmas is lower than the clinic. Further study with a larger sample size and more complete dimension is needed.

Keywords: Clinic, patient satisfaction, private primary health care, public health center

Introduction

The Alma Ata Declaration in 1978 and the Astana Declaration in 2018 have made primary health care (PHC) the foundation of the Sustainable Development Goals (SDGs) in 2030 to achieve Universal Health Coverage (UHC).[1–3] Health care can be provided through public and private providers. The government usually provides public health care through national healthcare systems.[4] In Indonesia, as mandated by law, the government has launched the National Health Insurance (*Jaminan Kesehatan Nasional*, JKN) program, which is expected to become a reliable program to achieve UHC gradually.[5] Health service providers include all health facilities that cooperate with the Healthcare and Social Security Agency (*Badan Penyelenggara Jaminan Sosial Kesehatan*, BPJS Kesehatan) in the form of first-level Health Facilities (*Fasilitas Kesehatan Tingkat Pertama*, FKTP) and advanced-level referral Health Facilities.[6]

A PHC is carried out at the FKTP, consisting of public health centers (*Pusat Kesehatan Masyarakat*, Puskesmas), private practices

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(general practitioners and dentist), *Pratama* clinics (government and private sector), and class D Pratama hospitals.[6] Puskesmas is a health service facility that organizes public health efforts and first-level individual health efforts, by prioritizing promotive and preventive efforts, to achieve the highest level of public health in its working area.[7] Meanwhile, private clinics are primary health services that belong to the private sector.[8] Private health care can be provided through "for profit" hospitals and self-employed practitioners, and "not for profit" non-government providers, including faith-based organizations.[4]

Health services often get many complaints from their patients. As an effort to improve services, it is necessary to conduct the quality of the health services through the community satisfaction index as a measure of optimizing public performance by a government official to the community.[9] Based on the regulations of the Ministry of Administrative and Bureaucratic Reform of the Republic of Indonesia[10] each public institution should measure the level of customer satisfaction. Thus, puskesmas as public health care and clinics as private health services must measure the quality of their services. Patient satisfaction with the health services acquired is one of the factors to achieve the UHC target.[11]

Therefore, the number of visits to Puskesmas develops the perception that the patient has recieved a good service. However, this number of visits is not equivalent to patient satisfaction.[12] Other studies evaluated in the systematic review do not support the claim that the private sector is usually more efficient, accountable, or medically effective than the public sector. The public sector appears frequently to lack timeliness and hospitality towards patients.[4]

A study conducted in Denpasar[11] showed differences in health service satisfaction at the Puskesmas and clinics. Puskesmas have a better level of satisfaction than the private Clinic. Previous research on patient satisfaction in East Karawang[13] showed that patients are on a satisfying scale. Based on these studies, it is interesting to find out more about the level of patient satisfaction in health facilities in Karawang, especially public health centers and private clinics as well as on what dimensions the differences in patient satisfaction levels occur. This study aimed to determine patients' satisfaction in public and private primary health care centers in Karawang Regency, West Java, Indonesia.

Methods

This research was a quantitative analytic study with a cross-sectional method using a survey method. The total sampling technique was used by filling out a questionnaire survey conducted in November 2019. The inclusion criteria were patients who had come at least two times to the Puskesmas and Clinics in five subdistricts at Karawang Regency and aged between 18–60 years. The questionnaire was used to assess patient satisfaction, issued by the Ministry of Administrative and Bureaucratic Reform of Republic of Indonesia, modified by the Department of Public Health, Faculty of Medicine, Universitas Padjajaran. The questionnaire was based on nine satisfaction dimensions, with 29 questions using a Likert scale of five answers categories. The questionnaire was drafted with a 5-point Likert response scale ranging from 1 (not satisfied) to 5 (very satisfied). This questionnaire can determine the level of satisfaction of the Puskesmas and clinic, and on what dimensions differences in satisfaction between the two health facilities.

The validity of the questionnaire concerning the raw variance obtained was 38.1%. This questionnaire met the minimum requirements of 20% unidimensionality. The overall interaction reliability index between person and items was 0.94, including the excellent category. Furthermore, the reliability index of the person was in the suitable category (0.85) with a separation of 2.36, meaning that the data grouping was diverse; the more varied the group, the more representative the data. The item reliability index (0.93) was in the excellent category with a separation of 3.76, meaning that the data grouping was diversed.[14]

The data obtained were inputted into Microsoft® Excel 2019. Data analysis in ordinal form was transformed using the Rasch model, assisted by Winstep® software version 5.1.0. Then, the numerical data were analyzed by Chi Square Test on IBM SPSS Statistic 23 Version to determine the difference between public and private groups. The Research Ethics Committee of Universitas Padjajaran approved this study with ethical clearance no 1359/UN6.KEP/EC/2019.

Results

Of the 193 respondents who were included, 123 respondents were patients from Puskesmas and 70 from Clinics. The characteristics of respondents were based on age, gender, formal

Table 1 Characteristics of Respondents from the Public Health Care (Puskesmas) and Private Primary Health Care (Clinic) at Karawang Regency

Dimension	Health Facility		P-value
	Puskesmas (n=123)	Clinic (n=70)	
	n(%)	n(%)	
Age (Year)			
18–20	8 (6.5)	2 (2.8)	0.541
21–55	99 (80.5)	58 (82.9)	
>55	16 (13.0)	10 (14.3)	
Gender			
Female	96 (78.0)	57 (81.4)	0.712
Male	27 (22.0)	13 (18.6)	
Formal education			
Elementary school	58 (47.2)	25 (35.7)	
Junior high school	42 (34.1)	18 (25.7)	*0.001
Senior high school	22 (17.9)	18 (25.7)	
Diploma / Undergraduate	1 (0.8)	9 (12.9)	
Occupation			
Have a job	40 (32.5)	37 (52.9)	*0.006
Have no job	83 (67.5)	33 (47.1)	
Membership status of health insurance			
Membership of national health insurance (BPJS JKN-KIS)	88 (71.5)	61 (87.1)	*0.013
Non membership of any insurance	35 (28.5)	9 (12.9)	
House ownership			
Own house	93 (75.6)	57 (81.4)	0.643
Dwell	25 20.3)	11 (15.7)	
Rent	5 (4.1)	2 (2.9)	
Vehicle ownership			
Own vehicle	100 (81.3)	60 (85.7)	0.552
Do not have vehicle	23 (18.7)	10 (14.3)	
Two-wheeled vehicle			
Have	100 (81.3)	59 (84.3)	0.696
Do not have	23 (18.7)	11 (15.7)	
Four-wheeled vehicle			
Have	6 (4.9)	6 (8.6)	0.358
Do not have	117 (95.1)	64 (91.4)	
Income			
< RMW (Rp2,275,751.00)	84 (68.3)	37 (52.9)	
RMW (Rp2,275,751.00) to double RMW (Rp.4,551,430.00)	30 (24.4)	25 (35.7)	0.102
>double RMW (Rp4,551,430.00)	9 (7.3)	8 (11.4)	

Note: BPJS= *Badan Penyelenggara Jaminan Sosial*, JKN: *Jaminan Kesehatan Nasional*, KIS= *Kartu Indonesia Sehat*, RMW= Regional Minimum Wage

education, occupation, health insurance membership, house ownership, vehicle ownership, and income (Table 1).

Respondents at Puskesmas were generally (80.5%) aged 21–55 years, female (78.0%), had elementary school education (47.2%), and did not have a job (67.5%). Respondents, in general, had become members of JKN (71.5%), owned a house (75.6%). Respondents owned a vehicle, of whom 81.3% had a two-wheeled vehicle, and only 4.9% owned a 4-wheeled vehicle. In terms of income, respondents (68.3%) stated that they had an income below the regional minimum wage (RMW) (Table 1).

Table 2 Comparison of Satisfaction Levels between Puskesmas and Clinics

Dimension	Health Facility		P-value
	Puskesmas (n=123) n(%)	Clinic (n=70) n(%)	
Requirements			
Satisfaction	83 (67.5)	62 (88.6)	*0.001
Dissatisfaction	40 (32.5)	8 (11.4)	
Systems, mechanisms, and procedures			
Satisfaction	83 (67.5)	62 (88.6)	*0.001
Dissatisfaction	40 (32.5)	8 (11.4)	
Service time			
Satisfaction	75 (61.0)	59 (84.3)	*0.001
Dissatisfaction	48 (39.0)	11 (15.7)	
Cost			
Satisfaction	92 (74.8)	52 (74.3)	0.534
Dissatisfaction	31 (25.2)	18 (25.7)	
Product specification type of service			
Satisfaction	74 (60.2)	49 (70.0)	0.213
Dissatisfaction	49 (39.8)	21 (30.0)	
Implementer competence			
Satisfaction	74 (60.2)	50 (71.4)	0.163
Dissatisfaction	49 (39.8)	20 (28.6)	
Implementer behavior			
Satisfaction	76 (61.8)	47 (67.1)	0.534
Dissatisfaction	47 (38.2)	23 (32.9)	
Handling of complaints. suggestions, and advances			0.448
Satisfaction	69 (56.1)	54 (77.1)	
Dissatisfaction	54 (43.9)	26 (37.1)	
Facilities and infrastructure			
Satisfaction	84 (68.3)	57 (81.4)	0.063
Dissatisfaction	39 (31.7)	13 (18.6)	
All Dimensions			
Satisfaction	83 (67.5)	62 (88.6)	*0.001
Dissatisfaction	40 (32.5)	8 (11.4)	

Note: *Significant different if p<0.05

Similar to Puskesmas, respondents in the Clinic were generally (82.9%) aged 21–55 years, female (81.4%), graduated from elementary school (35.7%) and had a job (52.9%). A total of 87.1% of respondents had been members of the BPJS, owned a house (81.4%), and 84.3% owned a two-wheeled vehicle. Respondents at the Clinic stated that they had an income below the RMW (52.9%) (Table 1).

There were significant differences between patients at the Puskesmas and at the Clinic in terms of education (p=0.001), occupation (p=0.006), as well as the membership of health insurance (p=0.013) (Table 1). Besides, in term of patient satisfaction index for health services at the Puskesmas and the clinic, this study also found differences (p=0.001). Patients who went to the Clinic (88.6%) were more satisfied than the most patients who went to the Puskesmas (67.5%), Overall, patients' satisfaction level at Puskesmas was lower than at Clinics (Table 2).

There were 3 dimensions that had differences in satisfaction, including the requirements (p=0.001); systems,

mechanisms, and procedures (0.001); service time (p=0.001). The other 6 dimensions such as cost (p=0.534); product specification type of service (0.213); implementer competence (p=0.163); implementer behavior (p=0.534); handling of complaints, suggestions, and advances (p=0.448); facilities and infrastructure (p=0.063) were not proven to have differences in satisfaction (Table 2).

Discussion

The findings showed that the majority of respondents were patients at the Puskesmas. Both patients in Puskesmas and Clinics mainly were aged 21–55 years, female, members of the national health insurance, owned a house, a vehicle, and had an income below the regional minimum wage. However, in terms of education and occupation dimensions, the patients at the clinic have significantly differences than patients at the Puskesmas as well as the membership of health insurance ($p<0.05$).

The dimensions of formal education, occupation, and membership status in health insurance influenced the choice of health facilities. In contrast, other factors had no bearing on the decision to use a health facility. These results are consistent with a study in Jambi,[15] showing that formal education affects patients' choices in health care facilities. The higher a person's education level would affect how they access their information and knowledge to handle the problem that will affect their behavior, especially health behavior.[15] Occupational dimensions affected the patients' choice of health facilities. Most patients who had jobs preferred clinics while patients who did not have jobs preferred Puskesmas to obtain health services. Having a job means that the patients have a regular income so they could afford for better healthcare.

Membership on health insurance also affected the patients' choice of health facilities. According to research in India,[16] people with health insurance are more likely to choose to maintain their health in a hospital or clinic because they can afford it. Income and having insurance are essential determinants and imply that the poor have access problems.

Overall dimension shows that patients satisfaction were significantly different between Puskesmas and Clinic (p=0.001). Patients who went to the private clinic were more satisfied than most patients who went to the Puskesmas, especially in terms of requirements, systems, mechanisms, procedures and service time. The dimensions of requirements; system, mechanisms, and procedures; also service time were linearly related to patient satisfaction in both healthcare facilities. A similar study in Bali[11] contradicted this finding, showing that patients' satisfaction at the Puskesmas was higher than at the private clinic. Respondents at Puskesmas tend to be more satisfied than at government clinics and private clinics. It may be related to the level of education and JKN membership status. The education level of respondents who visited the Puskesmas tended to be lower than other types of FKTP. Respondents who received contribution assistance from the government (PBI) of 100% said they were satisfied with health services at the Puskesmas, possibly because they received contribution assistance from the government. Moreover, it may also relate to the increasing quality of puskesmas due to ISO accreditation. The lowest patient satifaction in private clinics is caused by dissatisfaction with the dimensions of physical appearance (tangible) quality due to the limited parking space and the inconvenience of the waiting room. The problem is probably related to the high number of visits to private clinics.[11]

Patient's satisfaction on the dimension of requirements was different between Puskesmas and the clinic. Another study conducted in Surabaya[17] reported that technical and administrative requirements should be relevant to the type of service provided. Apparently, to satisfy the necessity of Puskesmas and clinic is not complicated.[17] These prerequisites must be satisfied both actually and authoritatively in overseeing wellbeing administrations in wellbeing offices.[10]

The system, mechanism, and procedures at the Puskesmas and Clinic affected patient's satisfaction between the Puskesmas and the Clinic. Variables in the system, mechanism and procedures must be easy to understand, and information about service procedures should be displayed. Also, staff can assist by explaining procedures and the flow of services to patients. Similarly, the results of a study in Medan showed that a reasonable service procedure should be easy to understand, simple, and straightforward.[18]

Previous research on community satisfaction conducted at East Karawang[13] showed that the dimensions of communication and courtesy of medical personnel had met patient satisfaction. However, several other

dimensions have not met patient satisfaction, such as infrastructure, types of equipment, means of communication, and speed of service.[13] Besides, dimensions of speed of service affected patient satisfaction. The measurement could be seen from the service speed, waiting time, and consultation time with medical personnel.[10] These results are in accordance with the study in Sampit[19] which showed that health services are considered good if they could be served quickly without waiting too long, and services are considered terrible if they wait too long.

The limitation of this study is that the minimum number of samples required to assess the five sub-districts was not met. The sample of this study did not represent all patients in the Puskesmas and Clinics in Karawang Regency. Moreover, other dimensions that influence the difference in satisfaction levels between Puskesmas and clinics in this study are unknown. This study also has limitations on several dimensions of patient satisfaction, which are not different from patient satisfaction at Puskesmas and the Clinic. In-depth research on data collection and analysis needs to be conducted to examine which dimensions affect patient satisfaction. This is crucial as the results of this study can be the baseline for the Government of Karawang or even West Java to make policies related to health services.

In conclusion, the perception of patient satisfaction with the Puskesmas is generally lower than the clinic. Knowing the difference in satisfaction levels between Puskesmas and Clinics is very important to know the strengths and weaknesses of each. This data can be used as the primary material to improve the quality of health services. The quality of excellent health services will have an impact on increasing health rates in Karawang Regency. The management of the Puskesmas must evaluate this shortcoming because the Puskesmas as a governmental health facility must be comparable to those managed by the private sector. Further study with a larger sample size and complete-dimension is needed.

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