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ORIGINAL ARTICLE

CUSTOMERS' SATISFACTION AMONG URBAN AND RURAL PUBLIC HEALTH CLINICS IN STATE OF SELANGOR, MALAYSIA

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ABSTRACT

Health services are considered to be of good quality if customers' expectations and perceptions are well balanced. Determinants confirming customers' expectations will lead to satisfaction, while factors disconfirming it will result in customers' dissatisfaction, reduced compliance to physicians' treatment and deterioration in overall disease management. A cross-sectional comparative study was carried out from September till October 2008 to determine population satisfaction with health services provided by the public health clinics in Selangor. A total of 3840 respondents from the urban Health Clinics (HCs) and 4768 respondents from rural HCs were selected applying multi-stage random sampling from 54 HCs in nine districts from Selangor. Self-administrated questionnaires formulated by adopting SERVQUAL method based on modified five dimensions plus four dimensions of Clinics Corporation were used . Results showed the proportion of satisfaction among the population towards services provided by the public HCs was high at 86.1%. From X^2 bivariate analysis; satisfied respondents were significantly from Indian and Chinese ethnic community more than the Malays, more among the less educated, the older age category (more than 33 years old) and males' were slightly more satisfied than females. Patients who visited HCs more than three times were more satisfied than one time visitors. Occupation, marital status and HCs urban-rural locality were not significantly associated with customers' satisfaction level. All dimensions showed high satisfaction level especially on treatment outcome, except on health care workers (HCWs) caring and professionalism domains. Working as a team was slightly higher in the urban areas compared to rural area. Overall, the SERVQUAL score of all dimensions were higher among the urban respondents albeit not significant. Clients' perceptions were generally higher than expectations reflecting the high satisfactions among clients at 86.1%. Much improvement needs to be put into training HCWs to be more caring and adapting a professional attitude towards clients. Clients' satisfactions in the urban and rural HCs were almost equal and did not reflect a decrease of health services priority in the rural areas.

***Key words**: SERVQUAL, customers' satisfaction, health clinics, urban-rural locality, health care workers.*

INTRODUCTION

Malaysia is a multiracial country consisting of Malays, Chinese, Indian and other ethnic groups. In 2007, the population of Malaysia was estimated to be 27,173,600. Covering an area of 329 876 square kilometers, the population density is 82.0 people per square kilometer[1]. The highest proportions of the population at 66.7% are in the 15-65 years old; 28.7% are less than 15 years old and 4.4% are more than 65 years old.

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Malaysian health care system is based on the dichotomy provision of services by both public and private health providers. Concentrated among the urbanized dwellings and well of consumers, the private is mostly for profit organizations be it private hospitals, nursing homes and general practitioners that mainly caters the primary care services. The public health providers are mainly entrusted to the Ministry of Health that acts as a custodian to the health system in Malaysia as a whole. The many levels of care i.e. from sub districts levels, districts, state and national referral centres see the issue of an ever increase and growing demand for quality health care services from its' hospitals and health clinics that are scattered in the country to meet customers satisfaction.

The many issues faced by the nation have created a need for assessments and reform of services provided. Rapidly rising standard of living and advancements in medical services have led to an ever escalating consumer demand for quality health care. Realizing these issues, and to ensure that national health care provision meets world-class standards, the Ministry of Health strongly recommends various quality assurance initiatives, under the guidelines of the Vision for Health. Something that satisfies will adequately fulfill expectations, needs or desires, and, by giving what is required, leaves no room for lodge complaint[2]. Two points arise from these definitions. First, a feeling of satisfaction with a service does not imply superior service, rather than an adequate or acceptable standard was achieved. Dissatisfaction is defined as discontent, or a failure to satisfy. It is possible that consumers are satisfied unless something untoward happens, and that dissatisfaction is triggered by a critical event. Secondly, satisfaction can be measured only against individuals' expectations, needs or desires. It is a relative concept: something that makes one person satisfied (adequately meets their expectations) may make another to be dissatisfied (falls short of their expectations). Cleary (1999) associates it with valued outcomes such as higher patient adherence to health recommendation, to continued use of appropriate health service and to higher levels of general health/wellbeing[3]. Research has shown that patient perception of quality of care closely matches judgments by peers of their caregivers. Moreover, satisfied patient respond more positively to medical management and experience better clinical and functional outcomes. There are various problems faced by the patients in outpatient primary care like overcrowding, delay in consultation, lack of proper guidance etc that leads to patient dissatisfaction. Nowadays, the patients are looking for hassle-free and quick services in this fast growing world. This is only possible with optimum utility of the resources through multitasking in a single window system in the out patients unit for better services.

Pascoe (1983) defined patient satisfaction as a health care recipient's reaction to salient aspects of the context, process, and results of their service experience[4]. Ware et al. (1983) have a similar definition i.e personal evaluation of health care services and providers[5]. In the discourse concerning satisfaction, there are other terms that need differentiation, which include desires, expectations, requests, goals, patient choice and priorities. Johari et al. (2008) research on patients' satisfaction was defined as meeting the patient's request[6]. This definition was different to the definition of quality, which is "meeting the client's need".

SERVQUAL stands for Service Quality. SERVQUAL is a multiple-item scale for measuring consumer perceptions of service quality and was developed by A. Parasuraman, Valarie A. Zeithaml and Leonard L. Berry (1988). Measuring service quality seems to pose difficulties for service providers because of the unique characteristics of service: intangibility, heterogeneity, inseparability and perishability. In 1984, Parasuraman et al. made a substantial contribution to our understanding of the concept of service quality and the factors that influence it by identifying ''gaps", occuring in the organizations that can cause quality probelm. These quality problems, identified as "gaps" are actually received. The authors defined this

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difference as service quality. In this 22-item scale instrument, respondents are invited to indicate the extent of agreement/disagreement, ranging from ”strongly disagree” to ”strongly agree” using a seven-point Likert scale. The first 22-items will represent the ”expectations”scores. Subsequently, respondents are then asked to indicate their feelings about their own recent experiences of the service in question. The first 22-items asked are about an ideal service (expectations). The second 22-items asked are to gain information about respondents' recent experience of the service (perceptions). Satisfaction is then calculated as the width of the gap between ”expectations” and ”perception” (expectations-perceptions). A negative gap is usually anticipated, indicating ”ideal” services have not been completely fullfilled. Another factor to be considered is the amount of resources the provider could offer in order to meet clients' needs. It is not possible for providers to meet all the requirements of their clients. There is no doubt that quality care incurs costs. In order to give quality services to our clients, it is important to understand their expectations in health care; doctors need to perceive correctly what the patient wants in order to give services to meet their expectations.

This study was conducted in the state of Selangor in West Malaysia among the publicly owned urban and rural HCs. Selangor is Malaysia's most populous state with the nation's biggest conurbation. Selangor's geographical position in the centre of Peninsular Malaysia contributed to the state's rapid development as Malaysia's transportation and industrial hub. This created jobs and attracted migrants from other states as well as overseas, especially from Indonesia, the Philippines, Vietnam, Myanmar, Bangladesh, India, Pakistan, and China. In recent decades, the influx of illegal immigrants, particularly from Indonesia, has further contributed to Selangor's population. Selangor has a population of around 5 million (Department of Statistics 2008 estimate), the state's ethnic composition consisted of Malays 52.9%, Chinese 27.8%, Indians 13.3%, and other ethnic groups 6%. Selangor's main population centres are from the Petaling Jaya and Ampang Jaya municipalities (Department of Statistics 2007). Selangor's main population centres are Petaling Jaya (2007 est. pop. 550,000); Shah Alam (500,000); Klang (995,000) and Subang Jaya (400,000).

The report by Shaari, Department of Statistic Malaysia[7] (2001) had been used as a reference to delineate the urban and rural areas by a few determined criteria. Close observation of governmental hospitals and health clinics in the urban and rural areas showed that the urban hospitals are overcrowded and over utilized; while the HCs especially in the rural are underutilized. These reflect the high demand for inpatients' treatment that may have been avoided had the customers received the initial treatments in HC that incurred less cost; albeit the trade-off of high technology equipments that are rarely prioritized in HC restrictive budgets. Therefore, the purpose of this study was to determine and compare patients' satisfaction between the urban and rural HC in Selangor, to determine factors affecting patients' satisfaction and to determine the relationship between waiting time and patient satisfaction in HC customers. Lastly to propose recommendations based on this study's findings.

METHODOLOGY

This was a cross-sectional comparative study conducted from the first two weeks of September until the first two weeks of October 2008. From the nine districts in Selangor that represented 54 HCs scattered around urban and rural, a total of 3,840 respondents were selected from the urban HC and 4,768 respondents from the rural HC using multi-stage random sampling. Self-administrated questionnaires formulated by applying the SERVQUAL score method based on five dimensions (i.e. tangibles, reliability, responsiveness, assurance and empathy) plus four dimensions of clinics corporation (i.e. caring, professionalism, team-work provide professionally well trained staff or not and works as a teamwork, outcome of treatment). The five dimensions identified in the instrument of SERVQUAL (Service Quality) were:

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1.	Tangibles	Physical facilities, equipment, and appearance of personnel
2.	Reliability	Ability to perform the promised service dependably and accurately
3.	Responsiveness	Willingness to help customers and provide prompt service
4.	Assurance	Knowledge and courtesy of employees and their ability to inspire trust and confidence.
5.	Empathy	Caring, individualized personal attention.

The four dimentions related to clinics corporations whic have been used were:

1.	Caring	The contiuety of care by the same staff in one visit and/the next visits.
2.	Professionalism	Qualified well trained staff.
3.	Team work	Health clinic staff works together among them in giving treatment.
4.	Outcome	Effective treatment.

Samples were selected at medical registration counters according to date of birth of clients' aged 18 years and above. The questionnaire was pre-tested for face validation and once written consent was taken, it was handed to the customers' upon arrival (Expectation) and another set when they have finished obtaining the services from the HCs (Perception). The self administered method took about 30 minutes to one hour duration. The first set was on customers' expectation containing 20 items given upon patients' arrival to the HC. While the second set was on their perception, containing a matching set of 20 items given to patients when they have finished receiving the services from the HC. Customer's expectation is defined as what the customers wish or expect from the services before they obtain these services from the health care workers (HCWs) be it a family medicine specialists, a medical doctor, medical assistants or nurses at the HCs. Whereas customers' perception is defined as what the customers perceived after receiving the services from the HCWs at the HC.

Characteristics of customers collected were their age, gender, ethnics, educational status, occupation, marital status, HCs locality (whether urban or rural), number of visit to this clinic, satisfaction on the waiting time, on whether the HCWs were informative or not and general satisfaction. A five-point Likert scale was used for the above items. The scores ranged from 1 "strongly disagree", 2 "disagree", 3 "agree", 4 "uncertain or no change" to 5 "strongly agree". After the questionnaires have been coded and cleaned, the data was entered into SPSS software version 12.0, was analyzed descriptively and inferentially using the p value of <=0.05 as statistically significant and at the power of 80%.

The working hypotheses will be socio-demographic factors will influence patients' satisfactions and rural HCs will produce lower patients' satisfaction level. There will be some biases involved as clients were aware of the study and may not reflect their actual attitude secondary to Hawthornes' effects. They may also display the need to please the researchers involved even though the questionnaire was self filled and done in privacy.

RESULTS

The response rate in this study was 89.9% (8608 out of 8700). From the analysis to assess level of satisfaction; 86.1 % of the respondents were satisfied comparing with 13.9% who was dissatisfied. Respondents socio-demographic characteristics studied are age, sex, ethnicity, marital status, educational status, and occupational sector. Their age ranged from 10-92 years old but the mean age was 32.3 ± 12.1 years. Among the health centre corporate characteristic studied are professionalism (well trained staff),

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working as a team, level of continuous caring and how the customers perceive that they receive effective treatment outcome. From the 8700 included in the study they were 3467 males (40.3%) compared with 5141 females (59.7%). Almost all of the respondents were Malays at 70%, Indians at 15.6 % and Chinese at 12.8%. The least races seen were 'Other' races at 1.6 %. In term of age, division of age into two categories saw that the highest response rate at 74.7% were the age of 33 years old and above and this was followed by respondents who were considered as young i.e. less than 32 years old and bellow at 25.3%.

As for educational backgrounds, 36% of the respondents had completed their academic education and considered as highly educated (with university certificate or diploma) compared with 61.1% who completed their primary schools or secondary schools (considered as low level education), 2.9 % have no formal education and 0.1% did not answer the questionnaires. In term of respondents' occupational status, there were 24.3% of them who worked in the governmental sector or retired from it; 46.3% who worked in the private sector or self employed. House wives and students were at 29.4%. Most of the respondents 67.8 % had visited the involved HCs for three times and more, 13.3% had came for the first time and 18.9% had came for the second time. In term of distribution of respondents according to urbanization locality, there were 44.6% respondents from urban HCs and 55.4% from rural HCs. Table 1 shows the demographic characteristics of respondents.

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Table 1. Socio-demographic background of the respondents

Variable	N	%
Sex		
Male	3467	40.3
Female	5141	59.7
Age group		
Young age (32 years old and less)	2214	25.3
Old age (33 years old and above)	6390	74.7
Ethnicity		
Malay	6084	70.0
Chinese	0929	12.8
Indian	1368	15.6
Others	0135	01.6
Marital status		
Married	6061	70.4
Single	403	4.7
Widowed	2144	24.9
Education status		
No formal education	250	2.9
Low level education	5261	61.1
High level education	3097	36.0
Occupation sector		
Governmental sector/ Retired	2088	24.3
Unemployed (Students/house wives)	2535	29.4
Self employed/ Working in private sector	3985	46.3
Number of visits		
First time	1165	13.3
Second time	845	18.9
More than three times	5836	67.8
HC by locality		
Urban	3840	44.6
Rural	4768	55.4

Relationship of satisfaction and socio-demographic Factors

The proportion of satisfied respondents was higher from the urban HCs. Among the eight socio-demographic variables studied, there appeared to be clear significant associations between the variable of ethnicity, respondents' attendance frequencies, respondents'

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educational status, age and SERVQUAL five dimensions of the satisfaction, while there appeared to be marginal association between respondents' sex and patients' satisfaction. In contrast there is no significant association between urban and rural locality of HCs, respondents' marital status, and occupational sector with the patient's satisfaction level.

The study clearly showed that the overall highest scores of satisfied respondents were on the outcomes of receiving effective treatment, followed by empathy and assurance dimension, working as a team while the reliability and the responsiveness dimensions were almost at the same level. Satisfaction of respondents on professionalism and the caring aspect (continuity of treatment) dimension was the lowest.

There was no significant associations' between urban and rural HCs localities with all dimensions of SERVQUAL and Clinics Corporations as in Figure 1.

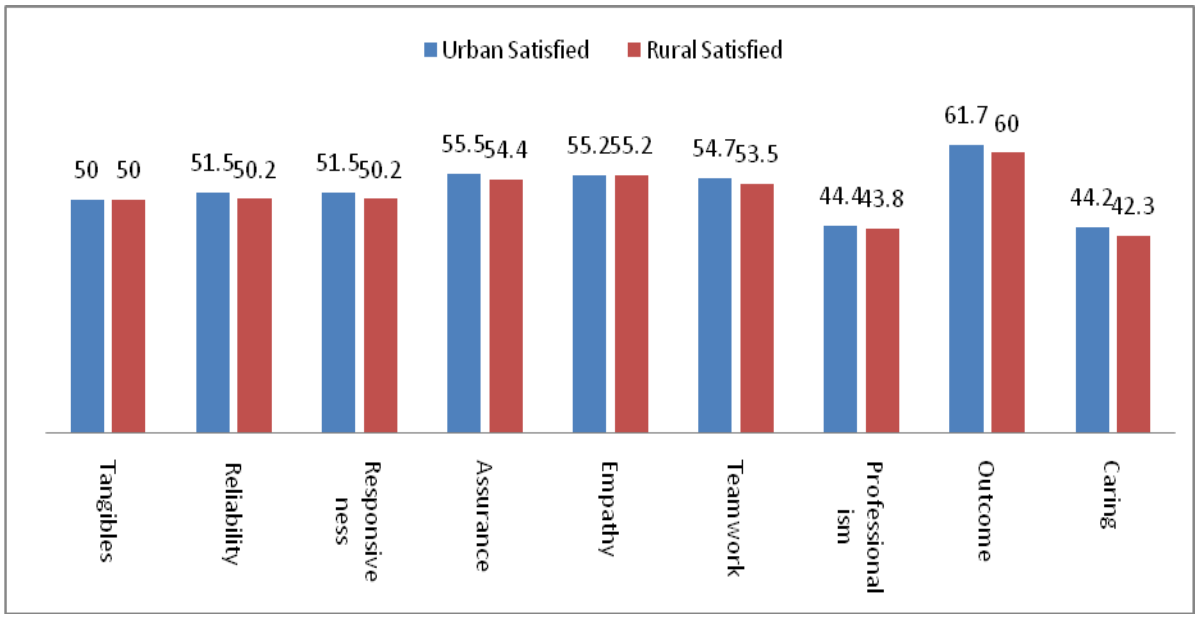

Figure 1. Proportions of SERVQUAL dimensions and urban-rural localities

There were significant associations' between the old and young clients' and assurance, responsiveness, teamwork, professionalism and caring dimensions of SERVQUAL and Clinics Corporations. Figure 2 shows that the older clients were more satisfied compared with the young clients.

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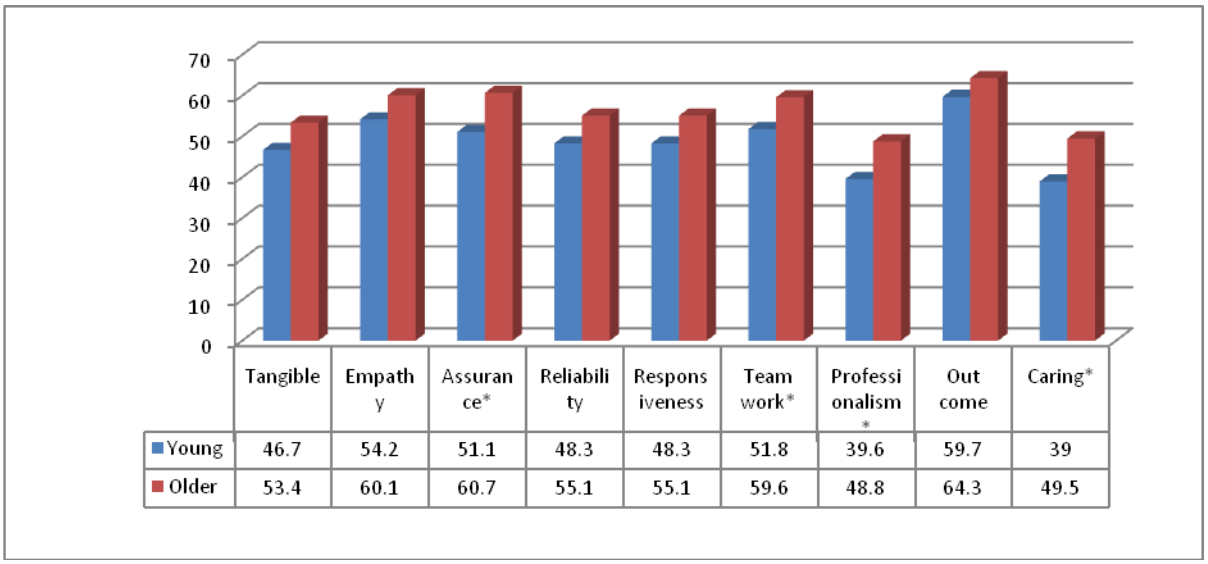
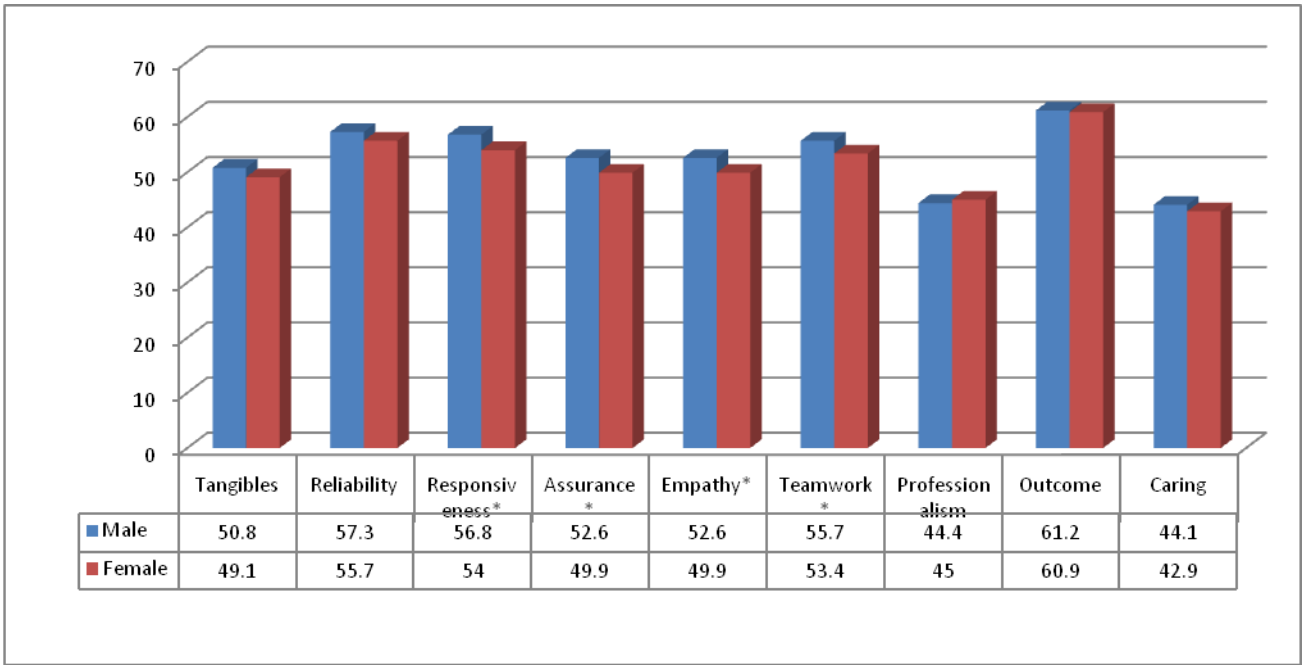


	Tangible	Empathy	Assurance*	Reliability	Responsiveness	Team work*	Professionalism*	Out come	Caring*
Young	46.7	54.2	51.1	48.3	48.3	51.8	39.6	59.7	39
Older	53.4	60.1	60.7	55.1	55.1	59.6	48.8	64.3	49.5

**significant at p<0.05*

Figure 2. Proportions of SERVQUAL dimensions and age categories

There were significant associations' between respondents' gender with dimensions of responsiveness, assurance, empathy and teamwork. Males had better satisfaction than females on these significantly different domains (Figure 3).



	Tangibles	Reliability	Responsiveness*	Assurance*	Empathy*	Teamwork*	Professionalism	Outcome	Caring
Male	50.8	57.3	56.8	52.6	52.6	55.7	44.4	61.2	44.1
Female	49.1	55.7	54	49.9	49.9	53.4	45	60.9	42.9

**significant at p<0.05*

Figure 3. Proportions of SERVQUAL dimensions and Gender

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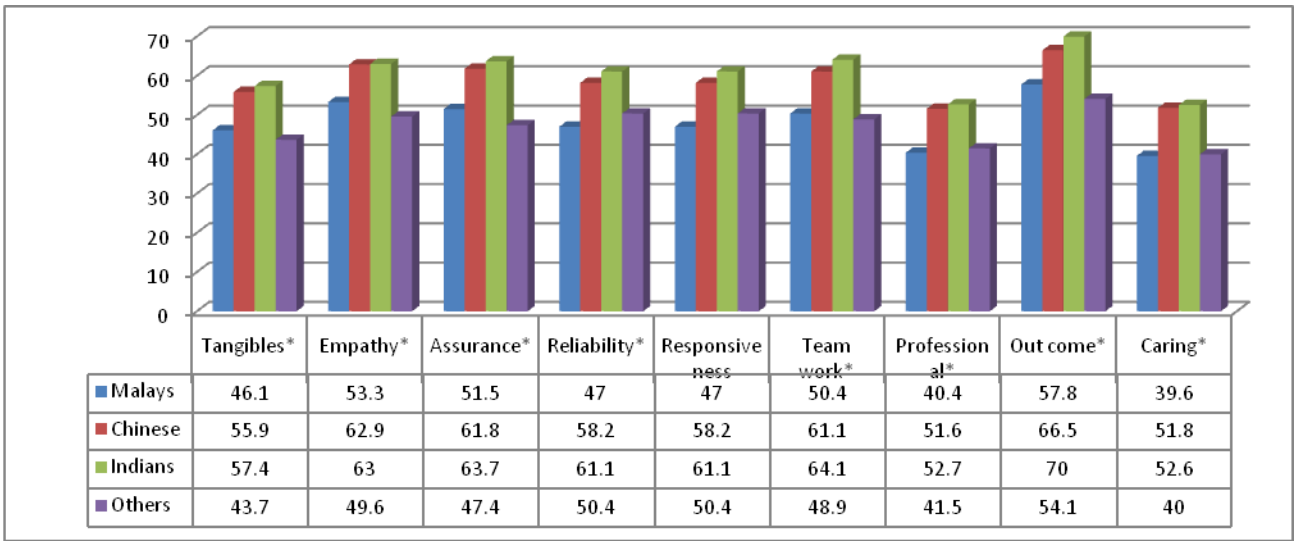
Chinese and Indians ethnicities had higher perceived satisfaction level on tangible, empathy, assurance, reliability, teamwork, professionalism, outcome and caring except responsiveness. Malays and Other ethnicities had lower satisfaction level than Chinese and Indian ethnicities (Figure 4).



	Tangibles*	Empathy*	Assurance*	Reliability*	Responsiveness	Team work*	Professional*	Out come*	Caring*
Malays	46.1	53.3	51.5	47	47	50.4	40.4	57.8	39.6
Chinese	55.9	62.9	61.8	58.2	58.2	61.1	51.6	66.5	51.8
Indians	57.4	63	63.7	61.1	61.1	64.1	52.7	70	52.6
Others	43.7	49.6	47.4	50.4	50.4	48.9	41.5	54.1	40

**significant at p<0.05*

Figure 4. Proportions of SERVQUAL dimensions and ethnicity

Between different marital statuses, there were no significant relationships between marital statuses in all SERVQUAL domains as in Figure 5.

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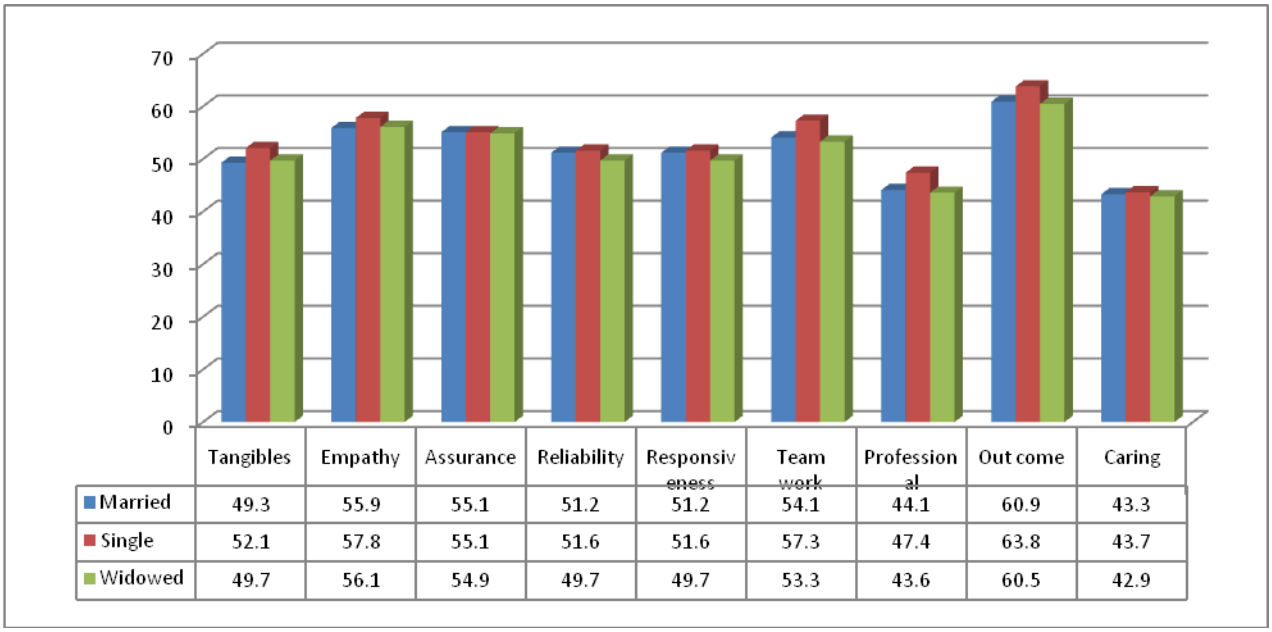

	Tangibles	Empathy	Assurance	Reliability	Responsiveness	Team work	Professional	Out come	Caring
Married	49.3	55.9	55.1	51.2	51.2	54.1	44.1	60.9	43.3
Single	52.1	57.8	55.1	51.6	51.6	57.3	47.4	63.8	43.7
Widowed	49.7	56.1	54.9	49.7	49.7	53.3	43.6	60.5	42.9

Figure 5. Proportions of SERVQUAL dimensions and marital status

There were significant relationships between education level with tangible, empathy, assurance, reliability, responsiveness, teamwork, professionalism, outcome and caring dimensions (Figure 6). The low education level was associated with higher satisfactions levels compared with the high education level that had lower satisfactions.

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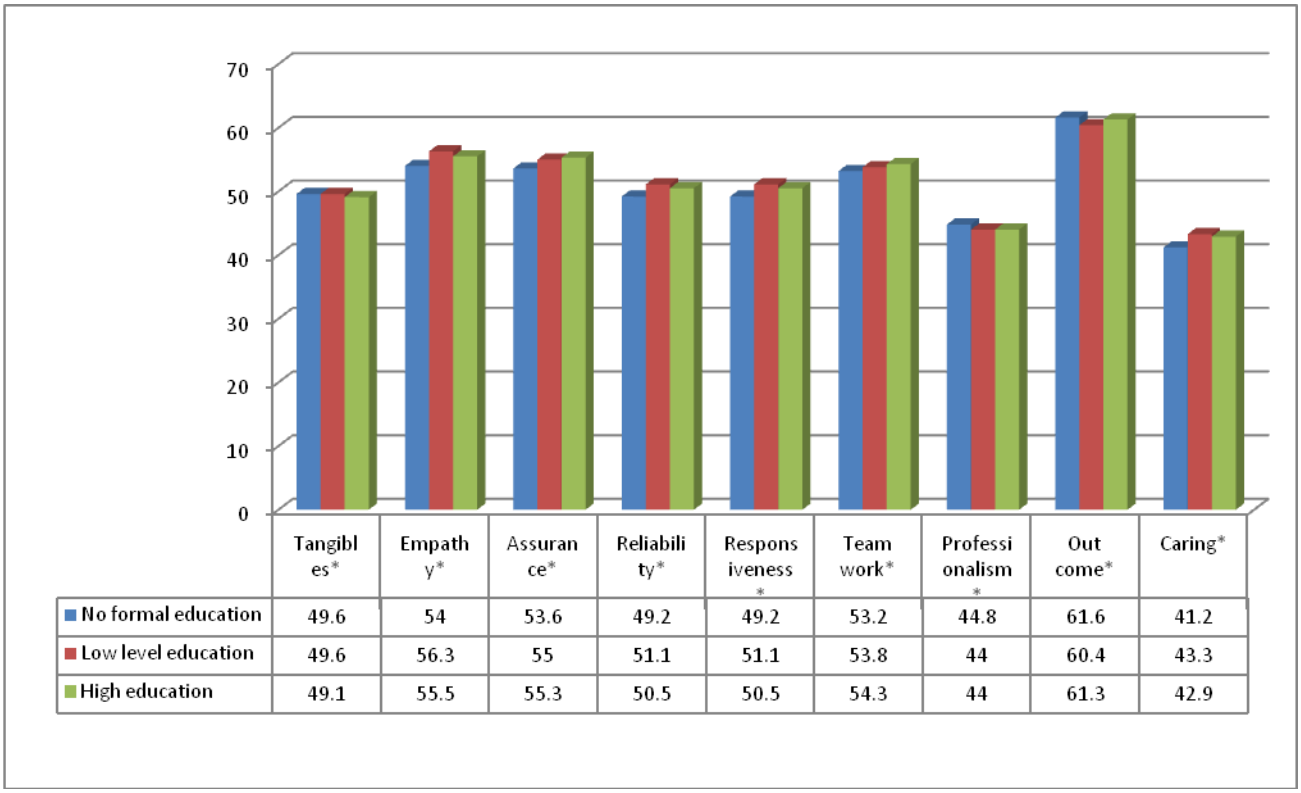

	Tangibles*	Empathy*	Assurance*	Reliability*	Responsiveness*	Team work*	Professionalism*	Out come*	Caring*
No formal education	49.6	54	53.6	49.2	49.2	53.2	44.8	61.6	41.2
Low level education	49.6	56.3	55	51.1	51.1	53.8	44	60.4	43.3
High education	49.1	55.5	55.3	50.5	50.5	54.3	44	61.3	42.9

Figure 6. Proportions of SERVQUAL dimensions with education Level

By occupation status, in Figure 7, there was no significant relationship between occupation status and all SERVQUAL dimensions.

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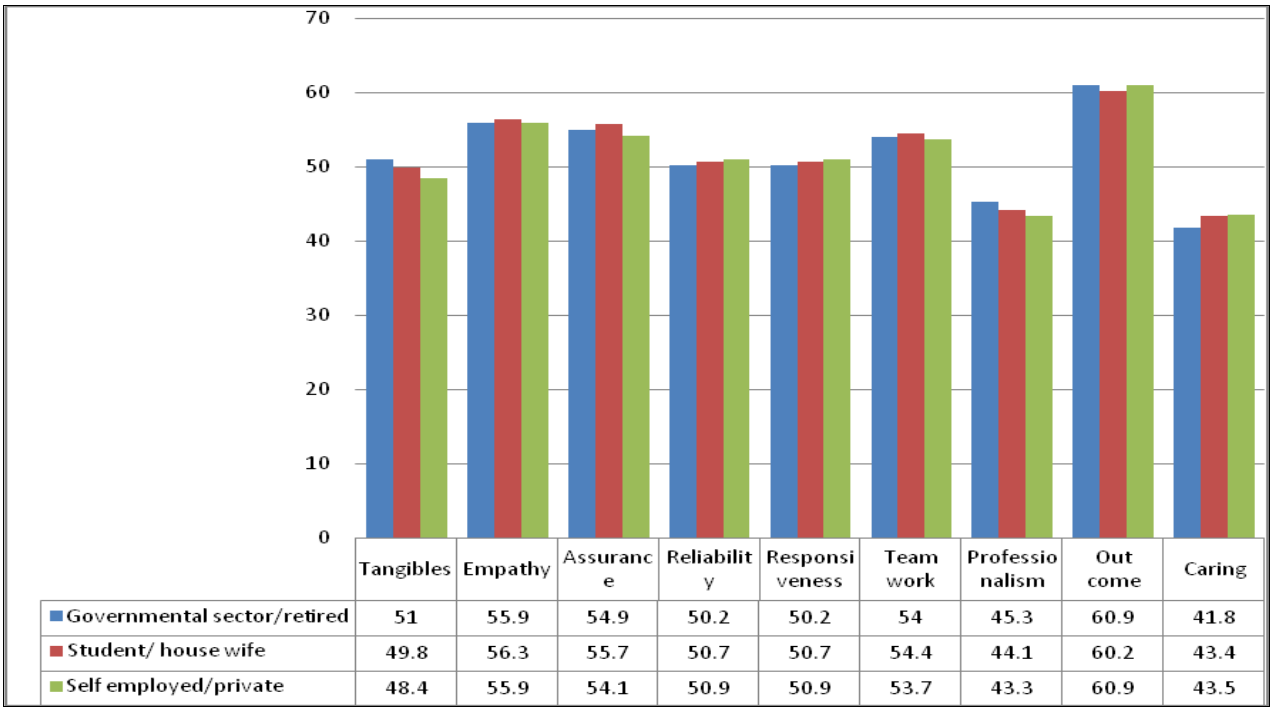
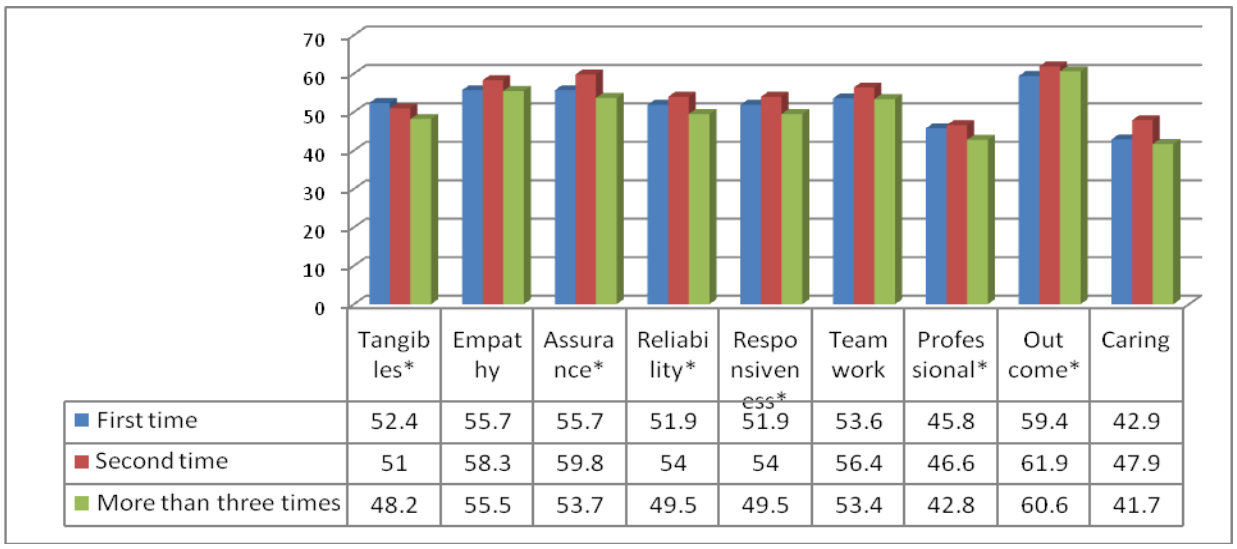


	Tangibles	Empathy	Assurance	Reliability	Responsiveness	Team work	Professionalism	Out come	Caring
Governmental sector/retired	51	55.9	54.9	50.2	50.2	54	45.3	60.9	41.8
Student/ house wife	49.8	56.3	55.7	50.7	50.7	54.4	44.1	60.2	43.4
Self employed/private	48.4	55.9	54.1	50.9	50.9	53.7	43.3	60.9	43.5

Figure 7. Proportions of SERVQUAL dimensions and occupational status

In the test of associations between SERVQUAL satisfactions dimensions and frequency of clients' visits; it was found that after at least three visits, the clients' satisfaction deteriorates. This was significant for dimensions on tangibles, assurance, reliability, responsiveness, professionalism and outcome as in Figure 8 below.



	Tangibles*	Empathy	Assurance*	Reliability*	Responsiveness*	Team work	Professional*	Out come*	Caring
First time	52.4	55.7	55.7	51.9	51.9	53.6	45.8	59.4	42.9
Second time	51	58.3	59.8	54	54	56.4	46.6	61.9	47.9
More than three times	48.2	55.5	53.7	49.5	49.5	53.4	42.8	60.6	41.7

**significant at p<0.05*

Figure 8. Proportions of SERVQUAL dimensions and frequency of clients' visits

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Regarding the appropriateness of waiting time before and after receiving treatment at the involved health clinics, it was found that 66.0% of the respondents were satisfied. When asked about whether the staffs were informative or not: 84.8%of the respondent found the staff was informative. Total levels of overall satisfaction among clients were high at 86.1% (Figure 9).

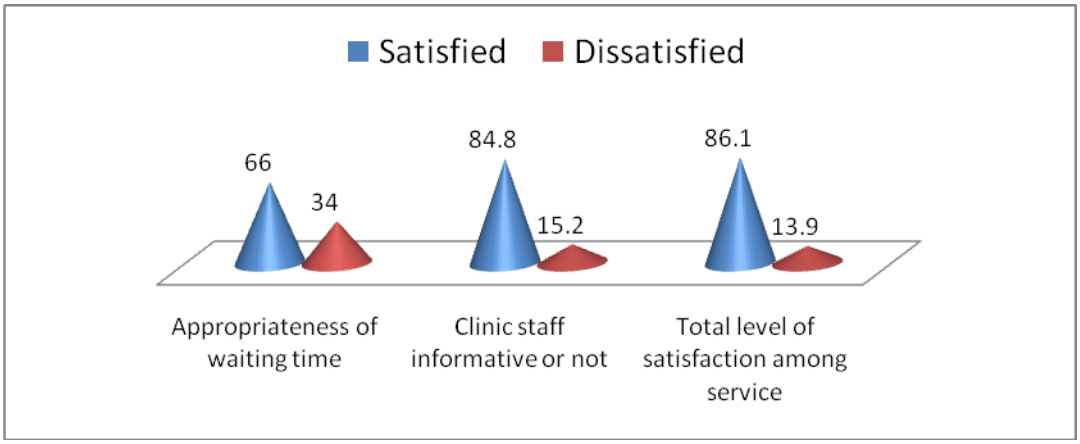

Figure 9. Satisfactions on HCs waiting time, informative staffs and total satisfaction level

DISCUSSION

The response rate in this study was 89.9% (8608 from 8700), which can be considered as acceptable response comparable to other studies such as by Johari et al. (2005) who did a study to measure patients' satisfaction in public hospitals with the response rate of 62% (13,463 from 21,750)[8]. The possible reason for good response rate in this study was most probably because this involved government health clinics that were committed in the management of patient satisfaction and their stake holders. The other possible reason could be that the study was conducted anonymously with the individual replying directly to the researchers. Apart from that, the structured questionnaire which was used in the collection of data could has also played a role in motivating the respondents to response as it took a short time and is a way to express clients' satisfactions or dissatisfactions.

Concerning urban and rural locality, many literatures have documented that location including distance is a very important factor, especially greater distance into the rural that might hinder people from obtaining the health services and finally reducing their satisfaction level. This is quite alarming especially for the senior people that already plagued with chronic diseases. In Sharifa Ezat et al. (2008), using SERVQUAL method of measuring 248 clients' satisfaction level, she found that rural community (78%) was more satisfied with Posyandu (rural health services by the community) services in Sumatera compared with its' urbanites (69.6%)[9]. However this difference was not statistically significant. This was the same result that was portrayed in this study, finding that showed their satisfaction levels across all study domains were similar between urban and rural HCs and no significant difference were detected.

In age categories, it was found that the older age group had significantly higher satisfaction level in the domains of assurance, teamwork, professionalism and caring domains. This was similar with the results from Sharifa et al. (2007 and 2008)[9,10], Nora'i et al. (2008)[11]. The older age expects less and higher perceivements. Younger age group may feel higher empowerments' to express their dissatisfaction and criticize more

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freely than the elderly thus having higher dissatisfaction levels. Males had better satisfaction levels on significant domains of responsiveness, assurance, empathy and teamwork; while female clients showed lower satisfaction levels on all domains. These were similar to Johari et al. (2006)[12] that did a similar study in a public hospital; Sharifa Ezat et al. (2007)[10] among attendees in public HCs in Negeri Sembilan and Nora'i et al. (2007)[13] among clients attending Putrajaya HC. Their studies showed that males had statistically higher satisfaction than females. These could be due to better quality of services perceived by males respondents compared to the female counterparts. Women are seen to be more picky and sensitive to informal body gestures or communications that they perceive as negative and hence create dissatisfactions.

Between all ethnicities, the Indians had statistically higher satisfaction levels on all domains except on responsiveness which was not significant. This was followed by other ethnicities i.e. the Chinese, Malays and Other ethnicities. This result was consistent with other studies results i.e. Sharifa Ezat et al. (2007) that showed the Malays had higher dissatisfaction (78.9%), compared with the non Malays (55.2%)[10]. Johari et al. (2006)[12] also displayed the similar pattern from his study of public satisfaction from a public hospital. It showed the Malays had statistically significant highest dissatisfaction compared with other ethnicities. This is also consistent with the findings from Nora'i et al. (2007)[13]. Why Malays had the most dissatisfaction could be because they perceived too high a quality of services that they never received in the end and felt disappointed.

Among the three levels of educational status, it was found that low education level was associated with higher satisfactions levels compared with the high education level that had higher dissatisfactions. This was consistent with Johari et al. (2006)[12], Nora'i et al. (2007)[13]; Sharifa Ezat et al. (2007 and 2008)[9,10]. In this study, there were significant relationships between clients' educational level with the domains of tangible, empathy, assurance, reliability, responsiveness, teamwork, professionalism, outcome and caring dimensions. As consistent with these studies, the factor why this happen is apparently similar. The highly educated will be the more knowledgeable, affluent and more easily to express their dissatisfactions.

In the test of associations between SERVQUAL satisfactions dimensions and frequency of clients' visits; it was found that after at least three visits, the clients' satisfaction significantly deteriorates. This is true if patients become frustrated and dissatisfied after HCWs may not understand their needs and expectations[2] (Hadi and Roslan 2006). This result is also consistent with Nora'i et al. (2008)[11] that found the same result. The more visits the patients encounter, the more unlikely their expectations are being met and this could be due to more frequent the visits, the HCWs do not see the need to satisfy patients need as adequately as in the first encounters.

Marital status and occupation status had no significant relationships with satisfaction level on all domains; and in this study we did not measure patients' income. This is similar with other studies findings (Sharifa Ezat et al. 2007 and 2008)[9,10]. As patients come in multiple presentations and attitude, these inert factors (such as clients' marital status and occupation) did not come as the first things to be noticed by HCWs; thus these factors did not influence or play a role as how clients are being treated by HCWs. However in Sharifa Ezat et al. (2008); clients' income played a role in influencing patients' satisfaction level[9]. It was noted that clients who earned more income/wealthy, perceived higher satisfactions but also dissatisfactions. This finding was similar but not significant in Sharifa Ezat et al. (2007) although higher income also experienced higher dissatisfactions towards services received[10].

A high percentage of patients' perceived the HCs waiting time as appropriate at 66%, but we did not ask the time that they waited in the HCs before or after seeing the doctors. In Sharifa Ezat et al. (2008); she found respondents' waiting

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time of less than 30 minutes to be satisfactory at 25.9% only while 78.9% identified the waiting time of more than 30 minutes to be dissatisfactory[9]. A high percentage (84.8%) of respondents perceived the staffs were informative and were satisfied with that. This is a good sign as the percent is higher than the percentage of respondents satisfied with the waiting time. While 86.1% of total respondents perceived their general satisfaction as satisfactory. It seems that majority of its attendees were satisfied with the services rendered by its HCWs. This is not consistent with another study by Haliza et al. (2005) using a different tool the PSQ II (Patients Satisfaction Questionnaire II) that found that only a minority of 16.7% was satisfied with public HCs compared with a higher proportions of clients at 83.3% was satisfied with private health clinics services[14].

The most satisfying dimension was outcome. It showed that most customers are assured with the treatment and management provided by HCWs in the involved HCs. This is interesting that showed that even though they might not have confidence with other domains such as professionalism, customers were still satisfied with treatment outcomes. Other dimensions satisfaction rates were not significantly different; although the least satisfied dimensions were of professionalism and the aspect on continuous caring. These two domains reflected the least satisfactory dimensions perceived by the customers that attended the HCs. HCWs need to instill professionalism and a more caring attitude in the HCs when treating patients.

RECOMMENDATIONS

Based on this study, results had shown that certain factors contributed to clients' satisfaction level. These included clients' gender, ethnicity, education level and number of visits to the HCs. These factors although may have been discovered and redundant with other study findings, this was never done in a major scale among attendees in HCs involving thousands of patients covering one populous state in Malaysia. The risks factors of contributing to lower satisfactions i.e. the younger age group, ethnicities of Malays and other minorities, high educated clients are more associated with higher dissatisfactions and thus have to be focused upon during serving their health needs to them. Appropriate health management that includes higher professionalism and a caring attitude will make our patients felt treated as clients in a more 'personalised' manner and felt their self worth not jeopardized. As health care is a one sided and of asymmetrical information / knowledge possessed by only the HCWs, training the HCWs of how to attend to the clients' grouses will increase patients satisfactions. Increasing the HCWs attitude and motivations to provide quality services has been talked about without any sign of a horizon. These are multipronged approaches that are too lengthy to be discussed and cannot be elaborated as the focus in this paper. However, the patients' expectations must be understood and heavily considered in treating patients medical conditions that brought them to the HCs medical attentions in the first place.

CONCLUSION

As a conclusion, Malaysian public health care organizations at its' smallest level i.e. primary care HCs are well prepared to achieve patient's satisfaction as shown here that majority were satisfied with the health care provided in HCs whether urban or rural. This was significantly contributed by a comprehensive and adequate training of its' HCWs. However continuous assessment of services quality provided should be continued and improvements must be taken into considerations by health care managers on deficits that were found from routine clients' satisfactions surveys.

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