CLIENT SATISFACTION FROM HEALTH PROMOTION SERVICES OF A PRIVATE HEALTH PROMOTION CENTER

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The Private Health Promotion Center (PHPC) is the first Health Promotion Center in Thailand and South East Asia. The Center offers health promotion service to the public. The study assessed the clients' satisfaction of the PHPC, which had never been done since the Center had commenced services. The purpose of this cross-sectional explanatory study was to measure the clients' satisfaction regarding health promotion services at PHPC. In addition, this study was aimed at determining the relationships between access dimension, service provision and service quality according to clients' perception and clients' satisfaction. The data were gathered from February 22 to March 31, 1999 at PHPC. One hundred and thirty-five (135) respondents were interviewed by using structured questionnaires.

Results revealed that the majority of the clients were female (51.9%) with an average age of 60 years; most of them were married (96.3%), holding bachelor degree (57.0%) and government officials (87.4%). Median income was 30,000 Baht per month. Regarding the source of information, 51.1% said they had heard of PHPC from companies. Most of them (99.3%) had been to the PHPC for the first time; 81.5% had reasons for joining the program because of employer arrangement, and 94.8% intended to continue with PHPC services. The overall satisfaction level was moderate (55.8%), but the satisfaction with courtesy was at a high level (47.4%). Satisfaction with information was at a low level (41.5%), and satisfaction for convenience, quality of care, coordination and cost were at moderate levels with the percentages of 58.9%, 56.3%, 45.1% and 43.7% respectively. The overall access dimension level was high (62.9%); service provision according to clients' perception was good (39.3%) and clients' perception of service quality was good (44.4%). The access dimension, service provision and service quality according to clients' perception were positively related to clients' satisfaction. The results of Stepwise Multiple Regression Analysis indicated that the significant relative contributor factors determining variation in clients' satisfaction were ample service, availability and continuous service which could account for 37.6% of variation in clients' satisfaction. It is recommended that satisfaction of clients at PHPC can be increased by rotating the hospital staff to the center by way of dealing with staff shortage problem. Moreover, the provision of adequate equipment, amenities and prompt service, clarifying information needed, improving public relations and marketing, and reducing the cost of the service would also enhance client satisfaction.

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CHAPTER I

INTRODUCTION

RATIONALE AND JUSTIFICATION

The 4th International Conference on Health Promotion New Players for a New Era: Leading Health Promotion into the 21st Century, meeting in Jakarta from July 21 to 25,1997 has come at a critical moment in the development of international strategies for health. It has been almost 20 years since the World Health Organization's member states made an ambitious commitment to a global strategy for Health for All, and the principles of primary health care through the Declaration of Alma-Ata. It has been 11 years since the First International Conference on Health Promotion was held in Ottawa, Canada. (WHO, 1997: 261)

The five strategies set out in the Ottawa Charter for Health Promotion are essential for success firstly, build public health policy, secondly, create supportive environments, thirdly, strengthen community action, fourthly, develop personal skills, fifthly, re-orient health service. (WHO, 1997 : 262)

Health is a basic human right and is essential for social and economic development. Increasingly, health promotion is being recognised as an essential element of health development. It is a process of enabling people to increase control

over, and to improve, their health. Health promotion, through investment and action, has a marked impact on the determinants of health so as to create the greatest health gain for people, to contribute significantly to the reduction of inequities in health, to further human rights, and to build social capital. The ultimate goal is to increase health expectancy and to narrow the gap in health expectancy between countries and groups. (WHO, 1997 : 261)

National governments are called on to take the initiative in fostering and sponsoring networks for health promotion both within and among their countries. The participants call on WHO to take the lead in building such a global health promotion alliance and enabling its member states to implement the outcome of the Conference. A main part of this role is for WHO to engage governments, non-governmental organizations, development banks, organizations of the United Nations system, interregional bodies, bilateral agencies, the labour movement and cooperatives, as well as the private sector, in advancing the priorities for action in health promotion. (WHO, 1998)

At present Thailand is changing rapidly. During the 7th National Economic and Social Development plan (1992-1996), the economic growth was successfully high at an average of 7.8 percent per annum. But economic activities and prosperity were clustered only in Bangkok and its peripheral areas. However, as a result of the economic expansion, most of the Thai people now have a better infrastructure and social services including telecommunications in the remote areas, while the environmental and cultural conditions as well as land use have been deteriorating.

Such situations have resulted in Thai people suffering from diseases of affluence such as heart disease, cancer, hypertension, AIDS, and injuries and deaths due to accidents. These health problems have shifted from infectious diseases to those related to social, environmental and behavioural problems. The trends are getting worse in the future. Thus, the 8th Plan (1997-2001) has set major strategies for health behaviour development for disease prevention and control, and health promotion by providing health information and education to the public. The health education and communications program has been specifically formulated with more budget so as to cover all health activities and all sectors of the population. (Ministry of Public Health, 1996:49)

The Private Health Promotion Center (PHPC) is the first such center in Thailand and in Southeast Asia. The PHPC is a multipurpose facility providing programs for: heart problems, weight reduction, stress control, diabetes control, stop smoking, and other health related conditions. It offers health promotion services to the general population. The programs the center offers stress both the theory and practice of a life style that enhances good health by applying eight secrets for healthy living (New Start).

The term "New Start" is an acronym derived from a study of the writings of Mrs. Ellen. G. White and developed by Dr. Vernon Foster of the Weimar Institude, a Seventh-day Adventist institution in Weimar, California. "New Start" stands for the eight secrets of good health which are: **Nutrition**--nourish your body with healthful, full-fiber nutient-rich foods and breaking the snack habit; **Exercise**--strengthen your

body and increase your enjoyment of life with daily active exercise; **Water**--enjoy an alternating hot and cold shower in the moring and drink six to eight glasses of water each day; **Sunshine**--to improve your health, let the sunshine into your body; **Temperance**--live a balanced life. Make time for work, play, rest and hobbies and protect your body from harmful substances such as tobacco, alcohol, caffeine and most drugs; **Air**--allow the fresh air to flow through your home and take frequent deep breaths while walking outside; **Rest**--aim for seven to eight hours of sleep each night and go to bed early; **Trust**--a life of quality and fulfillment includes spiritual growth and development. (Nelson, 1991)

From Lucker and Dunt's study (1978), consumer satisfaction was considered the prescription for action for improving services in some way that is beneficial to patients if not to the health care system as a whole. The distinct purpose of consumer satisfaction includes quality of care as outcome variables. Indicators from the aspect of service, need to be changed to improve patient response. Customer satisfaction is an important measure of service quality in healthcare organizations (Dansky, 1997 : 165). Having made their purchase and consumption decisions, customers enjoy the fruits of their labor in the form of a consumption experience. Consumption is a quintessentially subjective experience that varies widely from customer to customer. As Pirsig's quote reminds us, customers are the best judges of their own experiences. The pragmatic implication is that measure of perceived quality must come from customers themselves, measure derived from inside an organization are insufficient (Such as defect rater). As an output of their consumption experience, customers develop or update perceptions of product and service quality, expectations, and

evaluations of customer satisfaction. (Johnson, 1998 : 102). The use of data on customer satisfaction is growing rapidly, due in part to programs that seek continuous quality improvement. (Griffith, 1994 : 451-470).

A study assessing client satisfaction has never previously been undertaken since the Private Health Promotion Center open for services in 1990. The researcher was interested in assessing the client satisfaction and, therefore, undertook this study. The data can be used to improve service, to solve and avoid problems for the Center's administration. Clients who are satisfied may choose to return for further instruction. They will also promote the Center to their friends and, thereby, increase the number who will attend in the future, and thus support the policies for health improvement of the World Health Organization and stressing health promotion. Following this pattern, other organizations may establish similar centers for health promotion in the future.

RESEARCH OBJECTIVES

General Objective

To assess client satisfaction from health promotion services of a Private Health Promotion Center.

Specific Objectives

1. To measure level of client satisfaction from health promotion services of a Private Health Promotion Center.

2. To describe access dimension according to clients' perception on availability, accessibility, accommodation, affordability and acceptability.

3. To describe service provision according to clients' perception on equitable, timely, ample, continuous and progressive services.

4. To describe service quality according to clients' perception on reliability, assurance, tangibles, empathy and responsiveness.

5. To determine the relationship between access dimension, service provision and service quality according to clients' perception and clients' satisfaction.

RESEARCH HYPOTHESES

1. Clients who have perception of good access dimension will have high satisfaction.

2. Clients who have perception of good service provision will have high satisfaction.

3. Clients who have perception of good service quality will have a high level of satisfaction.

SCOPE AND LIMITATION OF THE RESEARCH

This study focussed only on client satisfaction from health promotion services of PHPC. It is based on a self-administered questionnaire given to the clients who attended the PHPC between February 22 and March 31, 1999.

OPERATIONAL DEFINITIONS

Private Health Promotional Center (PHPC) refers to an educational organization or institution staffed by health care personnel with the sole purpose of educating people regarding the promotion of health and helping them put into practice at home the theories they have studied, practiced and learned while in residence at the center.

Health Promotion refers to the educational process intended to stimulate people to adopt a healthier lifestyle by taking control of all behaviors detrimental to their health and replacing these behaviors with positive alternatives.

Clients refers to the people who attend the programs developed and presented by the PHPC from January 1 to December 31, 1998 with the purpose of improving their health.

Client satisfaction refers to the positive stimuli or perceptions which occur when wants, needs and expected services have been met and exceeded. In this study there were six components of satisfaction assessed: convenience, coordination, courtesy, information, quality of care and cost.

Convenience refers to the ease and comfort with which the client obtains the various services and processes of the PHPC.

Coordination refers to the harmonious interaction of the PHPC's staff covering all units to ensure that the client receives proper services and attention at all times.

Courtesy refers to sympathy, friendliness, etiquette and proper manners demonstrated at all times toward the clients.

Information refers to the published materials and verbal instructions including seminars to facilitate and guide the clients through the various processes of the PHPC.

Quality of care refers to meeting and exceeding the clients' perceptions and expectations in all the aspects of the PHPC's services.

Cost refers to the amount of payment due from the client or sponsoring organization for services provided.

Access dimension refers to the measure of the clients' ability to enter and utilize freely whatever services he or she needs or desires. In this study five components were assessed: availability, accessibility, accommodation, affordability and acceptability.

Availability refers to adequacy of the supply of physicians, staff, equipment and facilities to meet the clients' volume and types of needs.

Accessibility refers to the location of supply and the location of clients, taking into account the clients' transportation resources and travel time, distance and cost.

Accommodation refers to the manner in which the PHPC's resources are organized and delivered to accept clients and includes the clients' ability to accommodate to these factors and his/her perception of their appropriateness.

Affordability refers to the prices of services provided as they may relate to a client's perception of worth or value for services received and relative to total cost of the program.

Acceptability refers to the degree of comfort and trust the clients feel towards the staff.

Service provision refers to the PHPC's policy to meet its own objectives as well as fulfill the clients' needs. In this study five components were assessed: equitable service, timely service, ample service, continuous service and progressive service.

Equitable service refers to service that is rendered equally and fair to all without favoritism utilizing the same standards for all.

Timely service refers to service that is provided on time and meets clients' needs.

Ample service refers to a service that includes adequate and appropriate location, staff and facilities.

Continuous service refers to care that is provided until healing has been achieved, or in the case of the PHPC, until the conclusion of the program.

Progressive service refers to a service that continually seeks to improve quality and develop more efficient ways to render the service.

Service quality refers to the ability of the PHPC to satisfy the client by meeting and exceeding his/her needs and expectations. In this study five aspects were assessed: reliability, assurance, tangibles, empathy and responsiveness.

Reliability refers to the service provided being done correctly the first time.

Assurance refers to the employee's ability to convey trust and confidence to the client.

Tangibles refers to the appearance of the facility and staff.

Empathy refers to the caring and understanding nature with which the service is provided to the customer by the staff.

Responsiveness refers to the delivery of prompt service by the staff.

VARIABLES

1. Independent variables

1.1 Access Dimension

- Availability
- Accessibility
- Accommodation
- Affordability
- Acceptability

1.2 Service provision

- Equitable Services
- Timely Services
- Ample Service
- Continuous Service
- Progressive Services

1.3 Service quality

- Reliability
- Assurance
- Tangibles
- Empathy
- Responsiveness

2. Dependent Variables

Client satisfaction

- Convenience
- Coordination
- Courtesy
- Information
- Quality of care
- Cost

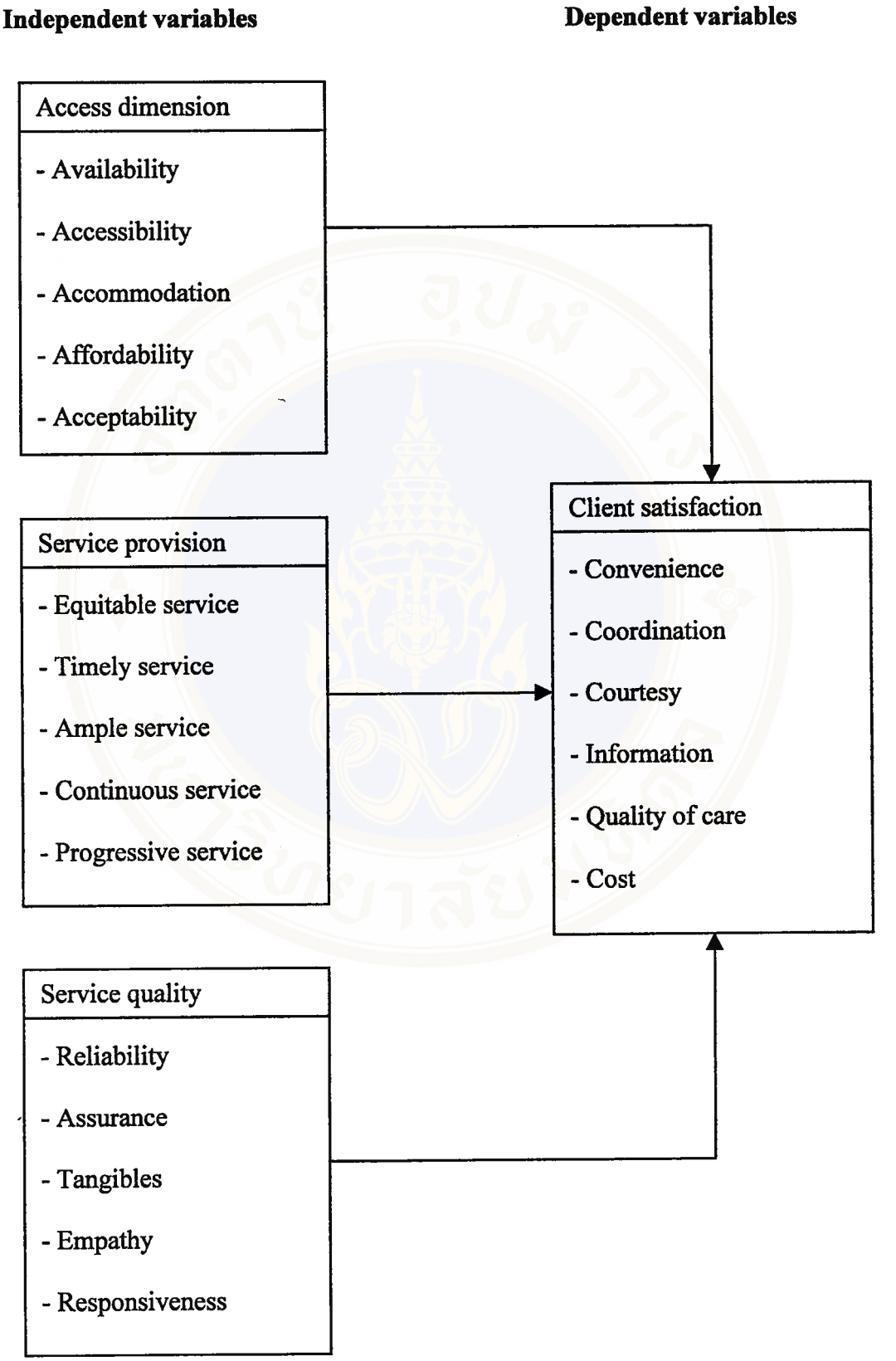

Figure. 1 Conceptual Framework

CHAPTER II

LITERATURE REVIEW

The literature review consists of the following:

1. Concept of Health Promotion and the Private Health Promotion Center
2. Theory and Concept of satisfaction
3. Concept about access dimension and service provision
4. Concept about service quality and perception
5. Reviews of relevant research findings

1. Concept of Health Promotion and Private Health Promotion Center

1.1 The Definition of Health Promotion

The World Health Organization (1986 : 5) defined health promotion as the process of enabling people to increase control over and to improve their health.

Meeks & Heit (1991:5) defined health promotion as the informing and motivating of people to maintain or adopt healthful behaviors.

Kuhn (1997:13) defined health promotion as a process through which healthy and health-inducing practices and types of behavior are made more rewarding for everyone in the enterprise.

Castillo-Salgado (1984: 349-358) defined health promotion as a combination of environmental, social, political, educational, economic, recreational and other types of activities designed to provide a healthy condition and prevent the activation and/or emergency of any disease process in individuals and collectivities.

In conclusion health promotion is an educational process intended to stimulate people to adopt a healthier lifestyle by taking control of all behaviors detrimental to their health and replacing these behaviors with positive alternatives.

1.2 **Concept of Health Promotion**

The participants in the Fifth International Conference on Health Promotion conference are committed to sharing the key messages of the Jakarta Declaration with their governments, institutions and communities, putting the actions proposed into practice, and reporting back to the committee. In order to speed progress towards global health promotion, the participants endorse the formation of a global health promotion alliance. The goal of this alliance is to advance the priorities for action in health promotion set out in this declaration. (WHO, 1997: 263)

The acceptance of health promotion as an important health strategy carries with it the need for the conceptualization, recognition, identification and designation of indicators or observable conditions. This allows the quantification and measurement of different activities, outcomes and processes related to the primary prevention interventions of health promotion. Therefore, the conceptualization of health promotion and the use of its principal components are logical steps towards the application of this health initiative in concrete programs. (Castillo-Salgado & Navarro 1997:341)

Today, concepts of health and health promotion can most fruitfully be analyzed and discussed in the context of a socioecological paradigm. On the basis of such a paradigm health has been defined in terms of two interrelated aspects of the socioecological system and the people belonging to it, health stability and health potential. In aiming to improve health potential, health promotion may be undertaken either to strengthen health resources or to reduce the health risks of individuals, groups or the whole community. The individual health approach attempts to strengthen the physical and psychosocial health potential of individuals and, as a desired consequence, individuals lifestyle and certain environmental health resources, particularly through immunization, health education and counseling. The community health approach is directed towards the improvement of economic, cultural, social, natural and technical health resources, and thereby towards the improvement of the personal lifestyle and health potential of individuals and social groups. It uses a large variety of political, legislative and administrative strategies and means. (WHO, 1997: 25-26)

1.3 The Private Health Promotion Center

1.3.1 Structure of Private Health Promotion Center

The Private Health Promotion Center is owned and operated by a private hospital in Bangkok. The Center emphasizes the promotion of both the theory and practice of a way of life that enhances good health. It is located among scenic surroundings with plenty of fresh air in Muak Lek sub district, Saraburi Province. The area is appropriate for the practice of the eight secrets for healthy living (NEW START). This Center includes nutritional and physical therapy components.

1. **Medical**

The Center provides detailed physical check-up that includes the function of the heart during physical exertion in order to evaluate the fitness of both the body and the mind. It also investigates one's susceptibility to sickness and is equipped with medical personnel who are ready to assist.

2. **Nutrition**

The Center provides low fat vegetarian meals for participants and demonstrates ways of cooking them. The recipes can be easily adapted to daily living.

3. **Physical Therapy**

The physical therapy unit has two functions.

a. Water therapy - refers to the use of hot and cold water to enhance the circulation of blood and renew balance to the body.

b. Body Massage - is used for relaxation and reduction of stress. These services are available for participants.

The Center provides accommodations, conference rooms for seminars, exercise room, and a swimming pool.

1.3.2 Methods of the Private Health Promotion Center

The Private Health Promotion Center has its particular methods for health promotion, the so called New Start program.

"**NEW START**" refers to the eight secrets for the enhancement of health based on the compilation of writings by Mrs. E. G. White by Dr. Vernon Foster who is associated with Weimar Institute (of Seventh-day Adventists) in California. These eight secrets are: nutrition, exercise, water, sunlight in appropriate amounts, temperance, fresh air, rest, and trust (in God). These eight secrets are incorporated into all aspects of this health promotion center and are utilized in the work of the hospital in the promotion of health. (Nelson, 1991)

1. **Nutrition**

The principal of nutrition according to NEW START emphasizes high fiber, low calories, low sugar and the use of unprocessed food such as vegetarian food

that is well known all around the world. Vegetarian foods with high fiber include fresh vegetables, fruits, brown rice and other types of nuts and seeds. It uses simple cooking methods that do not use spice, meat, and oil.

2. Exercise

Exercise is another strategy of the new start program to promote the development of body, mind, and spirit. Besides teaching the benefits of exercise and negative effects of the lack of exercise, this center promotes exercise through "walking" out in the fresh air, sunshine in appropriate amounts, scenic surroundings, and good ventilation. This type of exercise is appropriate for people of all ages and for those who may not feel so well. Other types of exercise include jogging, swimming and cycling to meet preferences of different individuals. What is important is to exercise no less than 30 to 60 minutes regularly.

3. The use of Water for the Renewal of Balance in the Body

The drinking of an adequate amount of water is stressed. Besides teaching basic knowledge about the use of water the center makes participants drink plain water every hour. Water is also healing to the physical body (for fever, headache, stress, and muscle pain) by using simple methods. For physical therapy, participants receive hot and cold water treatments and other forms of therapy that are learned and can be easily applied at home.

4. Sunshine

Sunshine has more health benefits than most people may realize. Besides the ability to nurture the skin and enhance the body's immune system, ultraviolet rays help rid the body of cholesterol by converting it to vitamins that will help absorb calcium. Participants need to learn the importance of sunlight since Asians, in general, tend to avoid it. Too much sunshine can cause skin cancer; however, moderate amounts benefit the body greatly. The center makes participants walk in the morning and evening. This provides appropriate amount of sunshine. They are also taught what appropriate amounts are and how to apply the principle when they return home.

5. Temperance

Temperance refers to the ability to abstain from activities that can impair physical health and also refers to the willingness to practice healthful living. We need to be temperate in our work and regarding the foods we eat. Of particular importance is the abstaining from addictive substances (tea, coffee, and alcohol). It is important to educate the mind to control not only one's appetite, but anything that leads to harmful excesses or tends to control the mind.

At the Center, temperance is incorporated into every aspect of the program such as diet, exercise, and especially with regard to tobacco addiction as this requires a lot of psychological adaptation. The approach is to ask participants to encourage themselves by "self-talk" such as repeating the phrase "I can do it." This helps one to fight an old habit and succeed. Another approach is to create an imagination of the benefits of abstinence and the bad consequences of addiction that

can happen to one's self, one's family, and one's environment. These approaches have been widely utilized.

6. Fresh Air

Fresh air is very important for good health. It affects our nervous and circulatory systems. The health center is encompassed by scenic surroundings with plenty of fresh air that participants can enjoy as they have their morning and evening exercise walks.

7. Rest

Sleeping helps our body to recuperate and get ready for the next day. Thus rest is a very important issue in life. The health center emphasizes the importance of at least eight hours of sleep each night. Participants learn different ways to help them sleep well. At the same time they also enjoy the scenery of the area to reduce their stress.

8. Trust in God

Trust in God is a way participants can have peace of mind. Participants also learn to have confidence that they will regain their good health because God will be with them and help them. To trust in God is a "Key" message that the health center wants their participants to grasp.

1.3.3 Health Promotion Program

The Private Health Promotion Center has its step by step packaged program on health promotion as follows:

1. **Physical Check Up**

   A Physical Check up is provided for participants before the seminars.

2. **Seminar on "Diet"**

   Vegetarian foods are provided for three meals a day. Nothing is served between the meals except water.

3. **Seminar on "Awareness of Sicknesses caused by Unhealthy Life Style"**

   Participants learn about different sicknesses that are caused by unhealthy living such as high blood pressure, fat, stress, etc. They also learn how to prevent these conditions by living a healthful life style.

4. **Seminar on "Exercise"**

   The Center provides "walking" in the morning and evening as a means of exercise. These walks last for about an hour. The swimming pool and the exercise room offer more opportunities for those who want it.

5. Seminar on "Water"

The importance of water is discussed. Participants learn about water therapy that they can practice at home.

6. Seminar on "Sunshine and Fresh Air"

Participants experience sufficient sunshine and fresh air at the center since it is located in a very scenic and rural environment. They also learn the importance of appropriate amounts of sunshine and plenty of fresh air.

7. Seminar on "Temperance"

Participants learn that it is very important to stay away from addictive substances such as coffee, tea, and tobacco. There is no special program for those who want to quit smoking.

"Six Days of Good Health"

The six-day course is considered short. It was adjusted from a fourteen-day course by eliminating some components.

Other courses

The health Center also provides other courses depending on the interest of the community. These might include "Health of Administrators," "Live a Happy Life after Retirement," "Happy Administrator," and "Diet for Children."

2. Theory and Concept of Satisfaction

2.1 The Definition of Satisfaction

Risser (1975 : 46) pointed out that patient satisfaction has been defined as "the degree of congruency between a patient's expectations of ideal nursing care and his perception of the real nursing care he receives.

Swan, et. al. (1985 : 7-8) proposed definition of patient satisfaction with medical care and nursing care in a hospital viewed patient satisfaction as a positive emotional response that is desired from a cognitive process in which patients compare their individual experience to a set of subjective standards.

Koontz, et. al. (1986) stated that satisfaction refers to the contentment experienced when a want is satisfied.

Oliver, (1993 : 65-85) stated the word "satisfaction" is derived from the Latin *satis* (enough) and *facere* (to do or make). A related word is "satiation," which loosely means "enough" or "enough to excess." These terms illustrate the point that satisfaction implies a filling or fulfillment. Thus, consumer satisfaction can be viewed as the consumer's fulfillment response.

Webster (1994 : 1193) recorded that satisfaction implies complete fulfillment of one's wishes, needs, expectations, etc.

In conclusion, clients' satisfaction occurs when wants, needs and expected services have been met and exceeded.

2.2 Theories on Satisfaction

Aday and Anderson (1974 : 208-218) mentioned consumer satisfaction is the attitude toward the medical care system of those who have experienced a contact with it which is different from the medical belief component of the predisposing variables in that it measure users' satisfaction with the quantity or quality of care actually received. They proposed that consumer satisfaction is probably best evaluated in the context of specific, recent, and identifiable episode of medical care seeking, relevant to consider in eliciting subjective perceptions of access that are satisfaction with the convenience of care, its co-ordination, and cost, the courtesy shown by providers, information given to the patient about dealing with his illness, and his judgement as to the quality of care he received. Patients' satisfaction is an outcome indicator in theoretical model of the access, which indicated the "use of service".

Ware et. al. (1975 : 429-436) reported that patient satisfaction survey data have been used as dependent variable to evaluate provider service and facilities, on the assumption that patient satisfaction is an indicator of the structure, process and outcome of care.

Lucker and Dunt (1978 : 283) stated that consumer satisfaction was considered as a prescription for action for improving services in some way that is

beneficial to patients if not to the health care system as a whole. The distinct purposes of consumer satisfaction includes evaluation of quality of care, as outcome variable, indicators of which aspect of a service need to be changed to improve patient response.

Cleary (1988 : 25-36) mentioned patient satisfaction with service is an important consideration in the quality of patient care and therefore, of interest to health services researches. For policy makers, "It is necessary to identify the specific ways in which information about patient satisfaction can be used" Two main criteria were presented for evaluating the relevance of satisfaction data to the organization and delivery of health services. First, it should be demonstrated that patient satisfaction is influenced by features of the organization that can be manipulated by policy changes. Second, satisfaction should be shown to be related to subsequent patient behavior. Good communication and attentiveness to patient concerns appear to be the strongest predicators of how patients will evaluate the care received.

Fitzpatrick (1991 : 887-889) mentioned in his survey of patient's satisfaction that there are some different dimensions of patient's satisfaction: humanness, informativeness, overall quality, competence, bureaucracy, access, costs, facilities, outcome, continuity and attention to psychosocial problems.

As provider, health professionals must consider to the six facets of autonomy of the consumer such as:

- Respect to patients
- Honoring family and friends' support

- Informing the patient about his/her diagnosis, disease and treatment.
- Insuring the patient has appropriate control of treatment as well as support from professional staff.
- Choice of practitioners, facilities and treatments
- Decision-making.

Mansour & Muneera (1993 : 163-173) mentioned that patient satisfaction studies historically began to appear in the health literature in late 1950'. At that time, there was a growing awareness of the patient as an evaluator of health care. Throughout the 1960's and 1970's many important studies were done that assessed the quality of health care as revealed by patients satisfaction.

For the purpose of this study concerning the clients' thinking about satisfaction on service, the concept of Aday and Anderson's conceptual framework was utilized. His concept was also utilized further for my study and evaluation below of the factors of convenience, coordination, courtesy, information, quality of care, and cost of service.

3. Concept about access dimension and service provision

3.1 The definition of access dimension

Penchansky and Thomas (1981 : 128) defined access as a concept representing the degree of "fit" between the clients and the system.

Newbrander (1997 : 235) defined access as the ability of people to use health services unimpeded by financial or social constraints, or by lack of facilities or providers.

Mirriam-Webster (1998) defined access as the freedom or ability to obtain or make use of . . .and, as permission, liberty, or ability to enter, approach, communicate with or pass to and from.

In conclusion, access is the clients' ability to enter and utilize freely whatever services they desire.

3.2 Concept about access dimension

Brown and Lewis (1976 : 267) stated that access to service of a hospital includes the following components:

1. Adequate place to give service
2. Adequate staff to meet patient's needs and expectations
3. Modernized up-to-date health care system
4. Provide holistic medical care to the patient

Cunningham, et al., (1995 : 739-754) offered a concept about accessibility to service based on the following:

1. Affordability—Patient must pay cost of service. Without payment there is no treatment or service.

2. Availability—adequate emergency room and emergency treatment phase and subsequent hospital service system.

3. Convenience—service hours, location of hospital, and willing staff to provide service.

4. Access to specialties--the length of time for transportation, appointment and waiting time.

Penchansky and Thomas (1981 : 127-140) gave specific areas or dimensions of access as follows:

1. Availability, the relationship of the volume and type of existing services (and resources) to the clients' volume and types of needs. It refers to the adequacy of the supply of physicians, dentists and other providers; of facilities such as clinics and hospitals; and of specialized programs and services such as mental health and emergency care.

2. Accessibility, the relationship between the location of supply and the location of clients, taking account of client transportation resources and travel time, distance and cost.

3. Accommodation, the relationship between the manner in which the supply resources are organized to accept clients (including appointment systems, hours of operation, walk-in facilities, telephone services) and the clients' ability to accommodate to these factors and the clients' perception of their appropriateness.

4. Affordability, the relationship of prices of services and providers' insurance or deposit requirements to the clients' income, ability to pay, and existing

health insurance. Client perception of worth relative to total cost is a concern here, as is clients' knowledge of prices, total cost and possible credit arrangements.

5. Acceptability, the relationship of clients' attitudes about personal and practice characteristics of providers to the actual characteristics of existing providers, as well as to provider attitudes about acceptable personal characteristics of clients. In the literature, the term appears to be used most often to refer to specific consumer reaction to such provider attributes as age, sex, ethnicity, type of facility, neighborhood of facility, or religious affiliation of facility or provider. In turn, providers have attitudes about the preferred attributes of clients or their financial mechanisms. Providers either may be unwilling to serve certain types of clients (e.g., welfare patients) or through accommodation, make themselves more or less available.

In conclusion, this research has used the concept of Penchansky and Thomas to define the access dimension components of availability, accessibility, accommodation, affordability and acceptability.

3.3 The definition of service provision

Swansberg (1993 : 167) stated that the policy for service provision towards nursing service is to determine the standard approach for nurses. The provider provided activity in the ward and service provision to agree with policy of hospital, patients' expectations and patient's need.

Marriner (1992 : 7) mentioned that service provision means the determination of the policy and objective to identify a direction for situation to practice and follow the organization's objective.

In summary, service provision refers to the intent of the organization to adhere to its own policies and meet its objectives.

3.4 Concept about service provision

Kulathon Thanaphongthorn (1995: 303-304) stated the main components of service provision in five basic principles:

1. Agreement that services offered by an organization must benefit and meet the needs of the general population and not the needs of just a selected group.
2. Consistent and continuous service provision must be carried out as opposed to a practitioner's decision to cease or interrupt temporarily some services and then initiating them again.
3. Equity in service provision must be carried out consistently and not treat selected clients or groups of people with special privileges or favoritism.
4. Minimizing the expenses of services to the client and assuring that costs are not above or more than results of services provided.
5. The resources of service provision should not be over-utilized, but provided sufficiently to ease and comfort the patient.

Wilson (1986 : 198) stated the provision of service activities should be considered in the light of customer satisfaction rather than purely in terms of profit. In this way, the cost of services can be treated as an essential item that is necessary in the creating of goodwill. Nevertheless, control must be exercised to prevent customers from taking undue advantage of facilities made available, but costs should strictly be reckoned with after a customer is operating satisfactorily rather than before.

Millett (1954 : 400) stated that satisfaction results from service provision to people that is based on the following:

1. Equitable services : service provision is rendered equally and fair to all without favoritism utilizing the same standards for all.

2. Timely service : service is provided on time and meets clients' needs.

3. Ample service : service provision that includes adequate and appropriate location, staff and facilities.

4. Continuous services : service and care provided continuously until healing has been achieved.

5. Progressive service : service Provision should continuously seek to improve quality and develop more efficient ways to render services based on the factors above.

In conclusion, taking into consideration the factors above, service provision is an overall efficient and cost-contained approach to services rendered to clients to meet their needs.

This research used Millett's concept for this study with components such as equitable, timely, ample, continuous and progressive services.

4. Concept about service quality and perception

4.1 The definition of service quality

Zeithaml, et. al. (1990 : 19) defined service quality as the extent of discrepancy between customers' expectation or desires and their perceptions.

Jirut Sriratanabal (1994 : 171) defined service quality as the ability to meet the client's needs, and per an assessment whether service provided met stipulated standards.

Webster (1994 : 1099) defines quality as a characteristic, element or attribute, and the degree of excellence which a thing possesses.

Newbrander and Rosenthal (1997 : 178) admitted that quality of care is difficult to define; however, when the generic term quality of care is used, most people are referring to what we would call the *technical* aspects of quality, such as the provider's behavior and skill in making interventions and applying technology.

In conclusion, a service quality definition is illusive; but following study of several documents for this paper, it is the ability to satisfy the client by meeting his/her needs and expectations.

4.2 Concept about service quality

Donabedian (1980) has recognized in his work, that the judgment of quality is not simply a technical, professional matter. It also includes inter-personal aspects where the consumer's opinion is at least as important. There are six dimensions of health care quality that need to be recognized separately, each requiring different measures and different assessment skills, i.e. access to services, relevance to needs, effectiveness (for individual patients), equity (fairness), social acceptability, and efficiency and economy.

Maxwell (1984 : 1470-1) has suggested six aspects to quality of care : access to service, relevance to need for the whole community, equity, social acceptability, effectiveness, efficiency and economy. It should not be assumed that these can be independently assessed. Thus, the evaluation of health service effectiveness should be seen as part of a wider concern for quality of care. Nevertheless, with in this wide remit it is prudent to look separately at effectiveness issues because to do so entails standing aside from the day-to-day provision of care, whereas much that is done specifically to promote quality (e.g. quality circles medical audit and nursing audit) is at the level of the individual patient contact.

Parasuraman, et al. (1986 : 86-108) produced a tool for measuring client satisfaction in the service industry which includes five dimensions as follows:

1. Reliability : refers to having the service provided being correct the first time.

2. Assurance : refers to the employees' ability to convey trust and confidence.

3. Tangibles : refers to the appearance of the facilities and staff.

4. Empathy : refers to the caring nature of the service provided to the customer.

5. Responsiveness : refers to having prompt service.

Eriksen (1988 : 523-537) Offered the dimensions to assess service quality with the following: art of care, technical quality of care, physical environment, availability, continuity of care, and efficacy.

Scardina (1994 : 38-46) when adapting a marketing instrument to be applied for evaluation of patient's satisfaction with nursing care, identified five service dimensions: tangibles (the appearance of physical facilities, equipment, personnel, and communication materials), reliability (the ability to perform the promised services dependably and accurately), responsiveness (the willingness to help customers as well as to provide prompt services), assurance (the knowledge and courtesy of employers and their ability to convey trust and confidence) and empathy (the provision of caring, individualized attention to customer) as factors of services influencing patients' satisfaction.

Newbrander & Rosenthal (1997 : 179) indicated that some of the dimensions of quality that are commonly accepted are excellence and appropriateness of the clinical care rendered as judged by professional and societal norms, access, interpersonal relations or patient satisfaction, efficiency, continuity of care, consistency of care, and effectiveness of care.

Chang (1997 : 29) Offered dimensions to assess service quality with the following:

1. Physical environment – keep room clean and organized, control noise, air, light, temperature in room

2. Availability – respond promptly to call lights, provide care in a timely fashion, provide patients' needed care.

3. Technical skills – provide physical care to meet patients' basic needs, such as bath, food, hygiene, toilet, and ambulating; exhibit skills in doing procedures; be skillful, accurate, organized and thorough in providing care and performing skills.

4. Art of care – be courteous, friendly, caring, attentive, personalized, supportive, listening, patient, encouraging and considerate; consider patients' preferences and opinions; take time to provide care and information; consider patients' respect, privacy and dignity.

5. Explanation of care – orient patients to room, daily routine, and nursing care; help patients understand about health conditions, progress, and plan of care; tell patients expected outcomes for the hospitalization, teach patients and family how to follow medical regime for home care; use appropriate words and methods to

help patients and families understand information; provide accurate and complete information.

6. Continuity of care – have the same nurse most of the time, know the names of their nurses; nurses understand patient's health conditions, health care needs, and needed care; nurses monitor patient's condition and response to treatment.

7. Specific outcomes of care – patients are satisfied with pain control; pain was relieved; patients felt that nurses made them comfortable, clean, and refreshed; patients felt that nurses reduced their fears and concerns; patients felt calm, better, and secure; patients felt that nurses met their needs and nursing care was helpful.

8. Overall quality – overall satisfaction or quality

9. Future intent – intent to return to this hospital if needed in the future and would recommend this hospital to friends and relatives.

Chapnik (1997:45) stated a clear message to medical staff and care workers in her research: "doing it right the first time" decreases malpractice, damaged public image and client dissatisfaction. Hence, the improvement of the quality of care must use a framework of planning, measuring, monitoring and evaluating process setting in advance.

In conclusion, from the above considerations, the researcher used Parasuraman et. al,. for this study and used components such as reliability, assurance, tangibles, empathy and responsiveness.

4.3 The definition of perception

Berelson & Steiner (1964) defined perception as the process by which individuals select, organize, store, and interpret sensory stimulation into a meaningful and coherent picture of the world around us.

Kolasa (1969 : 211) defined perception as the experience people have as the proximate result of the sensory inputs. The process is one of selection and organization of sensations to provide the meaningful entity we experience.

Luthans (1985 : 156) stated that perception is much more complex and much broader than sensation. The perceptual process involves a complicated interaction of selection, organization, and interpretation.

Rasberry & Lemoine (1986 : 36) defined perception as the process of gaining insight and knowledge about the world through any of our senses, especially through seeing and hearing.

Mitchell & Larson (1987 : 78) stated perceptions are the result of cognitive processes that shape the way we think about the world.

Gordon (1991 : 37) defined perception as the process of sensing reality and the resulting understanding of view people have of it.

Moorhead & Griffin (1995 : 65) defined perception as the set of processes by which an individual becomes aware of and interprets information about the environment.

In conclusion, perception is the process by which the stimuli by fine sensation are interpreted in relation to environment.

4.4 Concept about perception

Scott & Mitchell (1981 : 75) stated that perception involves two basic processes: selection and organization. Incoming information must be screened and categorized in some way; the first being that people tend to perceive familiar stimuli more quickly than unfamiliar stimuli; and second, we quickly tend to recognize things we have strong feelings about—especially in terms of likes and dislikes.

Rasberry & Lemoine (1986 : 40) provided six processes for person perceptions:

1. *Physical proximity.* When we can be close to and interact with others, we formulate a first impression—a mental image drawn with certain attributes and qualities attached to the image. In developing impressions, we usually group or stereotype people into categories as a result of reactions or a transfer of thoughts.

2. *Self-esteem.* The perception process continues and takes on a different twist as we react to others and how they seem to perceive us. We seem to be more

attracted to those whom we perceive to *agree* with our perception of ourselves and others.

3. *Rewards and costs.* Further interaction usually takes place only when one or both individuals perceive it to be worthwhile.

4. *Discrepancies.* When discrepancies occur between self-image and how one is viewed by others, information gathering is affected and further interaction can be threatened. Future contact will be limited unless the wrong information is cleared up or the impressions are balanced.

5. *Perceived intent.* Generally, people can forgive and forget if they feel another's behavior was not intentional.

6. *Accurate perceptions.* As we get closer to interpreting correctly the information we perceive about others, our relationships grow. When that occurs people become better managers, the workforce is productive, and all involved are rewarded.

Gordon (1991 : 37) stated that different people are likely to have somewhat different, and sometimes contradictory, views or understandings of the same event or person. Rarely do different observers describe events or persons in exactly the same way. Often managers and their subordinates, coworkers, or supervisors see and describe the same situation differently . . . . Because our perceptions have a strong impact on our descriptions, our diagnoses of events, and our subsequent behavior, it is important to examine the perceptual process and some of the factors that affect it. Basically, the perceptual process takes place in two stages which are: (1) selection and (2) organization.

Moorhead & Griffin (1995 : 65-66) stated that perception actually consists of several distinct processes which include selective perception and stereotyping. Selective perception is the process of screening out information with which we are uncomfortable or that contradicts our beliefs. Stereotyping is the process of categorizing or labeling people on the basis of a single attribute or characteristic.

Perception is a process whereby sensory cues and relevant past experience are organized to give us the most structured meaningful picture possible under circumstances. Thus a perception is just a point-for-point representation of the stimulus field but includes objects, relationship and point of special focus. In no situation is the individual isolated from his previous experience. Therefore, he always perceives his environment not with a blank mind but with and expectancy or hypothesis about what he is going to perceive. He is prepared to see, hear, smell or full some particular type of things because preceding events have aroused certain process of knowledge or motivation.

As he receives the actual stimulus from the environment, his perceptual process enables him to confirm or correct his expectation. If the original hypothesis is very strong or the expectation is very strong, however, either because it has been confirmed many times in the part or because it is strongly motivated, a contradictory stimulus situation will have to be quite strong to perceived accurately. What we perceive is always our best guess about what is there on the basis of the available sensory cues and our past experience. Perception is very personal thing. It enables the individual to know where he stands in relation to the objects, condition and people in his environment and to act accordingly.

5. Reviews of relevant research findings

Mingorance et al. (1992) conclude in a study on the satisfaction of the users of health center: The levels of trust on the doctor, the time of dedication and the information given to the patient reach slightly lower than the ones found in literature. Personal treatment and interest towards the patient have been valued the best. Center space structure and timetable have been the most penalized variables. They conclude that there is a need of improving the nursing care, a need for information and all the professionals working in the center, with regard to the patients problems, which are the cause of their health consultation, as well as the need of enlarging the available space at the center.

Mowen, et al. (1993). In studies on waiting times and client satisfaction they found that patients in the emergency department who waited longer than their expected waiting time had significantly lower satisfaction levels than patients whose waiting time expectations were met or positively exceeded.

Bjurulf (1993) in his study of "Perceived needs and patient satisfaction in relation to care provided in individuals with rheumatoid arthritis" found that a good reception is more important than professional knowledge followed by the ability to inform about the disease and the ability to show empathy. There was a trend towards increasing satisfaction with information about medical problems with severity of the disease. The importance of a continuous dialogue between patient and physician with regard to fulfillment of patient expectations is emphasized.

Ross et al. (1993) measured patients' satisfaction with access to care, availability of service, technical quality of care, interpersonal care communication and financing of care. The relationship conducted within subgroups between patient satisfaction and preferences were found highest on technical quality of care (R^2=0.77) which considered completeness and quality of medical clinics, and facilities, thoroughness of examinations, skill and thoroughness of treatment followed by interpersonal care (R^2=0.63) considered friendliness, personal interest, respect and reassurance shown by the physicians and nurses and access to care (R^2=0.56) considered convenience, hours, waiting time. Patients who gave priority to access/quality care were somewhat older age group, lower income and education and less likely to be employed.

Likun (1996) studied the strategic issue for reducing patient waiting time and improving satisfaction with services at the out-patient department of the first affiliated hospital, Kunming Medical College, P.R.C. Findings linked long waiting times with patients' dissatisfaction. The association between waiting time and satisfaction were positive and significant.

Dulal (1997) studied factors affecting service satisfaction of tuberculosis patients at the National Tuberculosis Center, Thimi, Nepal. His findings indicated . . . that variables concerning characteristics of the service provider personality traits, quality of care and variables concerning characteristics of the service physical environment, efficacy and cost of supportive drugs were found to be significantly correlated with satisfaction.

Ansari (1998) studied client satisfaction toward health center services in urban Islamabad, Pakistan. She found significant association between the income groups, client perception towards health center facilities, behavior of health care providers, time schedule of the health center and treatment seeking time with the level of satisfaction, with the majority being less satisfied.

Salam (1998) studied factors influencing client satisfaction toward antenatal care service in the MCH Hospital Ratchaburi Province, Thailand. He found that the distance from their residence, means of transportation were found to have statistically significant association on the level of client satisfaction.

Boonchoo Chawchiangkhang (1998) studied an assesment of worker satisfaction towards health insurance service in Chao-Praya-Yommarach Hospital, Suphanburi Province, Thailand. She found that there was a positive relationship between service system, process, staff and satisfaction.

It has been proved that there are many factors affecting clients' satisfaction such as access to care, availability of service, quality of care, convenience, behavior or health care provider, means of transportation, distance from residence, etc. For the purpose of this study, the researcher selected some factors, i.e., access dimension, service provision and service quality to determine their relationship to client satisfaction.

CHAPTER III

MATERIALS AND METHODS

RESEARCH DESIGN

This cross-sectional explanatory research is aimed at assessing client satisfaction from health promotion service of PHPC.

POPULATION

All clients who attended the PHPC from January 1 to December 31, 1998 were the population of this study.

SAMPLE AND SAMPLE SELECTION

A total of 135 clients were included in this study. The sample size was calculated by the following formula (Daniel, 1995 : 180).

$$n = \frac{Nz^2pq}{d^2(N-1)+z^2pq}$$

n	=	The desired sample size
N	=	Total clients attended at PHPC from January 1 to December 31, 1998
z	=	The standard normal score
p	=	The proportion of consumer's satisfaction towards health care services
q	=	1-p
d	=	maximum allowable error

With 95% confidence, the 0.71 proportion of satisfaction towards health service provided (Devkota, 1997) and the maximum allowable error 0.05, the sample size was 197 persons. The total of 205 persons who attended the PHPC from February 22 to March 31, 1999 were recruited into the study.

RESEARCHER INSTRUMENTS

The instrument in this study was a questionnaire which was divided into five parts as follows:

Part I General characteristics of respondents which included sex, age, marital status, educational attainment, occupation, monthly income, sources of information, number of visits to the PHPC, reason for joining the program and intention to participate in the PHPC's program in the future.

Part II Access dimension which included 10 questions as follows:

Availability	2	questions (questions 11-12)
Accessibility	2	questions (questions 13-14)
Accommodation	2	questions (questions 15-16)
Affordability	2	questions (questions 17-18)
Acceptability	2	questions (questions 19-20)

Part III Service provision which included 46 questions as follows:

Equitable services	7	questions
Timely services	4	questions
Ample services	24	questions
Continuous services	4	questions
Progressive services	7	questions

Part IV Service quality which included 14 questions as follows:

Reliability	4	questions (questions 67-70)
Assurance	3	questions (questions 71-73)
Tangibles	3	questions (questions 74-76)
Empathy	2	questions (questions 77-78)
Responsiveness	2	questions (questions 79-80)

Part V Satisfaction on health promotion services. The level of client satisfaction was measured by five levels of the Likert Scale. It included 38 questions on the following:

Convenience	25	questions (questions 81-87)
Coordination	2	questions (questions 88-89)
Courtesy	4	questions (questions 90-93)
Information	2	questions (questions 94-95)
Quality of care	4	questions (questions 96-99)
Cost	1	question (question 100)

The questionnaire was pretested before the data collection. The content validity was agreed upon by the thesis advisory committee. The reliability of the questionnaire was performed by distributing the questionnaire to 30 clients who attended the PHPC from February 8-12, 1999. The Cronbach's coefficient of alpha was adopted for the reliability analysis of each part of the questionnaire as shown in table 1.

Table 1 Reliability Coefficient

Variable	Cronbachs's coefficient of alpha
Access dimension	0.3962
Service provision	0.7837
Service quality	0.4893
Client satisfaction	0.9806

DATA COLLECTION

Between February 22 and March 31, 1999, a total of 205 sets of questionnaires were distributed to PHPC clients who attended the center. Of these only 135 or 65.35% were completed and returned for analysis.

DATA ANALYSIS

1. Scoring and classification criteria

To assess the access dimension, service provision and service quality according to clients' perception, the scores 1 and 0 were assigned to the "Yes" and "No" responses respectively. The scores of each part were added and classified into low, moderate and high as shown in table 2.

For satisfaction on health promotion services of PHPC the following scores 5, 4, 3, 2 and 1 were assigned to the responses excellent, good, fair, bellow average and poor respectively. The summation of the scores for this part was obtained by assessing the overall satisfaction. Then it was classified into low, moderate and high levels of satisfaction as shown in table 2.

Table 2 Classification criteria for satisfaction, access dimension, service provision and service quality

Variable	Min-Max	Classification Criteria		
	Score	Low	Moderate	High
Satisfaction	**109-190**	**≤ 138**	**139-179**	**≥ 180**
• Convenience	71-125	≤ 89	90-119	≥ 120
• Coordination	6-10	≤ 7	8-9	≥ 10
• Courtesy	12-20	≤ 15	16-19	≥ 20
• Information	2-10	≤ 7	8-9	≥ 10
• Quality of care	12-20	≤ 15	16-19	≥ 20
• Cost	2-5	≤ 3	4	≥ 5
Access Dimension	**0-10**	**≤ 6**	**7-8**	**≥ 9**
• Availability	0-2	0	1	≥ 2
• Accessibility	0-2	0	1	≥ 2
• Accommodation	0-2	0	1	≥ 2
• Affordability	0-2	0	1	≥ 2
• Acceptability	0-2	0	1	≥ 2
Service provision	**25-46**	**≤ 41**	**42-45**	**≥ 46**
• Equality to service	4-7	≤ 5	6	≥ 7
• Timely service	2-4	≤ 2	3	≥ 4
• Ample service	13-24	≤ 18	20-23	≥ 24
• Continuous service	2-4	≤ 2	3	≥ 4
• Progressive service	1-7	≤ 4	5-6	≥ 7

Table 2 Classification criteria for satisfaction, access dimension, service provision and service quality (cont.)

Variable	Min-Max	Classification Criteria		
	Score	Low	Moderate	High
Service quality	**0-14**	**≤ 12**	**13**	**≥ 14**
• Reliability	0-4	≤ 2	3	≥ 4
• Assurance	0-3	≤ 2	-	≥ 3
• Tangibles	0-3	≤ 2	-	≥ 3
• Empathy	0-2	0	1	≥ 2
• Responsiveness	0-2	0	1	≥ 2

Statistics

1. Descriptive Statistics

The descriptive statistics, mean ± standard deviation, median and mode were applied for the quantitative type of data. The percentage and proportion were adopted for the qualitative data to describe the data being gathered. The Spearman correlation coefficient was used to explain the relationship between any two quantitative data, e.g. the scores of access dimension, service provision and service quality and the score of client satisfaction.

2. Inferential Statistics

T-test was applied to test for correlation between any two quantitative types of data. The Stepwise Multiple Regression was performed to select the factors that can best explain the satisfaction. The significant level for the analysis was set at 5%.

CHAPTER IV

RESULTS

This research was aimed at assessing the client satisfaction from health promotion services of PHPC. The data were collected by delivering 205 questionnaires to clients who attended PHPC from February 22, 1999 to March 31, 1999. Only 135 or 65.4% of the questionnaires were returned. The results will be presented in three parts as follows:

1. General characteristics of the clients of PHPC
2. Client satisfaction
3. Access dimension; service provision; and service quality.
4. Relationship between access dimension, service provision, service quality and client satisfaction.

1. General characteristics of the clients at PHPC

The ratio of male to female clients who responded to the questionnaire was almost the same. They were government officials and state enterprise officers who were preparing for retirement, therefore about three-fifths were 60 years old. Regarding the marital status 76.3% of the respondents were married and 57.0% were bachelor degree graduates. Most of the respondents (87.4%) were government officials and the rest of the respondents (12.6%) were engaged in state enterprise. For

monthly income two-third of them (70.4%) earned 20,001 to 40,000 Baht with the median of 30,000 Baht per month. Concerning the source of information about PHPC, more than half of them (51.9%) received it from the companies they worked for and one third (33.3%) heard about it from training/seminar. Reasons given for joining the PHPC's program, the majority of them (81.5%) reported that their employers arranged it. Three-fourth of the respondents (74.8%) indicated they will participate in the PHPC's programs in the future. (Table 3)

Table 3 Number and percentage distribution of general characteristics of the clients

General Characteristics	Number	Percentage
Number of clients	135	100.0
Sex		
Male	65	48.1
Female	70	51.9
Age (years)		
59	52	38.5
60	78	57.8
61	5	3.7
Marital Status		
Single	18	13.3
Married	103	76.3
Widow/Divorce/Separated	14	10.4

Table 3 Number and percentage distribution of general characteristics of the clients (cont.)

General Characteristics	Number	Percentage
Educational Attainment		
Less than secondary school	25	18.5
Diploma	16	11.9
Bachelor	77	57.0
Higher than bachelor	17	12.6
Occupation		
Government official	118	87.4
State Enterprise officer	17	12.6
Monthly Income (Baht)		
Less than 20,000 Baht	20	14.8
20,001 - 30,000 Baht	53	39.3
30,001 - 40,000 Baht	42	31.1
More than 40,000 Baht	20	14.8
Median	30,000	
Mean ± S.D.	31,793.79±13,487.49	
Min - max	7,600-100,000	
Source of Information about PHPC		
Document from PHPC	12	8.9
Document from other companies	69	51.1
Radio/Television	4	3.0
Newspaper	1	0.7
Friend/Relative	4	3.0
Training/Seminar	45	33.3

Table 3 Number and percentage distribution of general characteristics of the clients (cont.)

General Characteristic	Number	Percentage
Number of Visit to the PHPC		
First time	134	99.3
More than once	1	0.7
Reason for joining the program		
Own choice	8	5.9
Employer arrangement	110	81.5
Want to try	16	11.9
Other	1	0.7
Intention to participate in the program of PHPC in the future		
Yes	101	74.8
No	33	24.5
Not sure	1	0.7

2. Client satisfaction

Satisfaction from the service provided of PHPC was assessed and classified into 3 levels, i.e. low, moderate and high. For overall satisfaction most of the respondents had a moderate level of satisfaction (56.3%) while 26.7% had a high level and 17.0% had a low level of satisfaction respectively. Considering the six components of satisfaction, clients were the most satisfied with the courtesy of the staff (47.4%). On the other hand, 41.5% of the respondents rated information as the lowest position (Table 4).

Table 4 Percentage of level of client satisfaction on health promotion services (n=135)

Satisfaction	Percentage of level of satisfaction			$\bar{x}$ ± S.D.
	High	Moderate	Low	
Overall satisfaction	26.7	56.3	17.0	158.49±20.85
Convenience	23.0	59.2	17.8	103.24±14.61
Coordination	35.6	45.1	19.3	8.45±1.32
Courtesy	47.4	44.5	8.1	17.89±2.22
Information	18.5	40.0	41.5	7.55±1.68
Quality of care	28.1	56.3	15.6	17.29±2.16
Cost	31.9	43.7	24.4	4.07±0.76

Considering levels of satisfaction on the convenience of the seven services provided by PHPC, the cafeteria, room and seminar room were more convenient than the four other services. The high level of satisfaction on the convenience of these units were 36.3%, 35.6% and 32.6% respectively. Because the client had to be queued and wait, the convenience of the emergency room and physical therapy unit were rather low (34.8% and 30.4% respectively).

Table 5 Percentage of level of client satisfaction on convenience by unit. (n=135)

Convenience	Percentage of level of satisfaction			$\bar{X} \pm$ S.D.
	High	Moderate	Low	
Reception	22.2	51.1	26.7	16.56±2.34
Room	35.6	35.6	28.8	8.16±1.48
Seminar Room	32.6	47.4	20.0	12.65±1.97
Cafeteria	36.3	37.8	25.9	17.06±2.62
Physical Therapy unit	25.9	43.7	30.4	20.50±3.46
Emergency Room	20.7	44.5	34.8	11.85±2.12
Swimming Pool	23.7	49.6	26.7	16.45±2.54

Considering levels of satisfaction on coordination, courtesy, information, quality of care and cost, the level of good and excellent satisfaction for courtesy was the highest. For quality of care and coordination, the level of excellent and good satisfaction were next to courtesy. The least satisfaction was given to information. Only about 70% of the clients felt that the information and documents provided were good and excellent. For coordination, clients' perception was good and excellent for coordination among units (88.1% for good and excellent) more than staff teamwork (82.2% for good and excellent). Regarding quality of care, the convenience and promptness of the services were perceived rather low (30.4% and 53.3% in excellent and good) as compared to other items of quality of care, e.g. punctuality, schedule and activities provided. Concerning cost of the services, 75.6% of the clients rated good and excellent as reasonable (Table 6).

Table 6 Percentage of level of client satisfaction on health promotion services according to clients' perception by item (n = 135)

Categories	Percentage of level of satisfaction				
	Excellent	Good	Fair	Below average	Poor
Coordination					
• Staff teamwork	37.8	44.4	17.8	0	0
• Coordination among units	37.0	51.1	11.9	0	0
Courtesy					
• Staff manner	52.6	42.2	5.2	0	0
• Friendliness of staff	54.8	42.2	3.0	0	0
• Staffs attention for clients	51.9	44.4	3.7	0	0
• Information provided by staff	48.9	43.7	7.4	0	0
Information					
• Information provided to public and clients' organization	18.5	41.5	26.7	12.6	0.7
• Documents and instructions from the PHPC	24.4	45.9	25.9	3.0	0.7
Quality of care					
• Services convenient and prompt	30.4	53.3	14.8	1.5	0
• Scheduled service on time	40.0	53.3	6.7	0	0
• Schedule consistent	50.4	47.4	2.2	0	0
• Activities provided are consistent with the whole program	42.2	50.4	7.4	0	0
Cost					
• Reasonable	31.9	43.7	23.7	0.7	0

3. Access dimension; service provision; and service quality

3.1 Access dimension

The overall access dimension (62.9%) had a high level. Considering each of the five components of access dimension, most of the respondents rated them high, at 88.1%, 84.4% and 82.2% on availability, acceptability and accommodation respectively. The lowest percentages of access dimension were 65.9% and 65.2% on accessibility and affordability respectively (Table 7).

Table 7 Percentage of level of access dimension according to clients' perception (n=135)

Categories	Percentage of level of access dimension			$\bar{x} \pm$ S.D.
	High	Moderate	Low	
Overall access dimension	62.9	26.0	11.1	8.56±1.86
Availability	88.1	10.4	1.5	1.87±0.38
Accessibility	65.9	27.4	6.7	1.59±0.61
Accommodation	82.2	14.8	3.0	1.79±0.48
Affordability	65.2	20.7	14.1	1.51±0.73
Acceptability	84.4	11.1	4.4	1.80±0.50

For each category of the access dimension, at least 90% of clients responded that services provided met their needs, there were good supportive services, travel time was appropriate, length of program was appropriate and there were prompt answers to questions. However, convenience of transportation to the PHPC and the reasonable cost of program were perceived as poor (Table 8).

Table 8 Number and percentage of access dimension according to clients' perception by item (n=135)

Item	Percentage of access dimension	
	Number	Percentage
Availability		
• The service provided by the Center met client's needs.	127	94.1
• Supportive services such as rooms, swimming pool, rest areas, physical therapy were suitable and good.	125	92.6
Accessibility		
• Transportation to the center is convenient	90	66.7
• Length of travel time appropriate	125	92.6
Accommodation		
• Appropriate length of program	122	90.4
• Clear instruction about the service	120	88.9
Affordability		
• Reasonable cost	95	70.4
• Affordable cost	109	80.7
Acceptability		
• Adequate information promptly provided	114	84.4
• Prompt answer to questions	129	95.6

3.2 Service provision

For the overall service provision only 39.3% of the respondents rated it good. Considering service provision by items most of the respondents (89.6%) perceived timely service as good and only 49.6% rated ample service as good (Table 9).

Table 9 Percentage of level of service provision according to clients' perception (n=135)

Service provision	Percentage of level of service provision			$\bar{x}$ ± S.D.
	Good	Fair	Poor	
Overall service provision	39.3	37.7	23.0	42.98±4.34
Equitable service	84.4	14.1	1.5	6.82±0.45
Timely service	89.6	8.9	1.5	3.88±0.37
Ample service	49.6	37.1	13.3	22.18±2.68
Continuous service	85.2	10.4	4.4	3.81±0.50
Progression service	59.3	33.3	7.4	6.29±1.14

Considering level of service provision by service unit, a majority of clients rated as good the seminar room (91.9%), cafeteria (83.0%) and emergency room (81.5%). However, the perceptions on service provision at the swimming pool and physical therapy units were rather low since only 67.4% and 63.7% respectively rated them as good (table 10).

Table 10 Percentage of level of service provision according to clients' perception by unit (n=135)

Service provision	Percentage of level of service provision		$\bar{x} \pm$ S.D.
	Good	Poor	
Reception	71.9	28.1	7.55±0.93
Room	80.0	20.0	2.72±0.64
Seminar Room	91.9	8.1	5.91±0.31
Cafeteria	83.0	17.0	6.78±0.54
Physical Therapy	63.7	36.3	7.04±1.57
Emergency Room	81.5	18.5	5.57±1.05
Swimming Pool	67.4	32.6	7.41±1.07

Looking closely at each unit regarding the services provided, the majority of clients (at least 90%) perceived they were welcomed warmly when they arrived at the reception area. However, only two-third of the clients felt that telephone, fax and computer services were adequate. Regarding services provided in the seminar room and cafeteria almost all of respondents felt that they were very good. Respondents rated the amenities in their own rooms rather low due to the lack of television. Only 81.5% of them were satisfied with room amenities. Clients' perception regarding the physical therapy unit and the availability of rooms, seats, equipment and staff, were rather low. Less than 83% of them responded that they were adequate. Regarding the emergency room, cleanliness was rated as perfect. For other emergency room items, they were quite good. Clients' perception about all the swimming pool items were rather good, whereas 76.3% of them were satisfied with the number of seats (Table 11).

Table 11 Number and percentage of service provision according to clients' perception by item (n=135)

Service provision	Number	Percentage
Reception		
• Adequate space for reception	128	94.8
• Adequate space for rest area and for luggage.	128	94.8
• Adequate telephones, fax and computers for services.	102	75.6
• Drinking water provided	132	97.8
• Friendly Staff	134	99.3
• Luggage carrying and ushering provided	133	98.5
• Proper queuing for registration	130	96.3
• Fast accommodating procedure	132	97.8
Room		
• Room size suitable	128	94.8
• Good amenities	110	81.5
• Clean rooms	129	95.6
Seminar Room		
• Well ventilated	132	97.8
• Adequate light	135	100.0
• Noise well-controlled	131	97.0
• Adequate equipment	133	98.8
• Adequate staff	135	100.0
• Seminars conducted on time	132	97.8

Table 11 Number and percentage of service provision according to clients' perception by item (cont.)

Service provision	Number	Percentage
Cafeteria		
• Adequate seating	135	100.0
• Good ventilation	122	90.4
• Adequate eating utensils	134	99.3
• Adequate staff	121	89.6
• Polite staff	134	99.3
• Open on time	135	100.0
• Proper queuing for service	134	99.3
Physical Therapy Unit		
• Adequate rooms	112	83.0
• Adequate seats for clients	108	80.0
• Adequate equipment	110	81.5
• Clean and appropriate	127	94.1
• Adequate staff	106	78.5
• Helpful supporting staff	134	99.3
• Proper queuing for services	129	95.6
• Less waiting time	125	92.6

Table 11 Number and percentage of service provision according to clients' perception by item (cont.)

Service provision	Number	Percentage
Emergency Room		
• Well located, proper direction signs	130	96.3
• Clean/hygienic	135	100.0
• Adequate equipment	123	91.1
• Adequate medicines	121	89.6
• Staff always ready to serve	121	89.6
• Adequately staffed	122	90.4
Swimming pool		
• Proper size	134	99.3
• Adequate seating	103	76.3
• Adequate facilities	128	94.8
• Clean	132	97.8
• Staff/Lifeguard available	124	91.9
• Staff available to give advice	121	89.6
• Clean towels provided	131	97.0
• Regulations posted	127	94.1

3.3 Service quality

The overall service quality, was rated as good by 44.4% of the clients. Considering each component of service quality, most of the respondents felt that 97.0%, 93.3%, 92.6% and 85.9% on empathy, assurance, responsiveness and tangibles respectively were good. Reliability of service (51.9%) in the good level was rather low (Table 12).

Table 12 Percentage of level of service quality according to clients' perception (n=135)

Service quality	Percentage of level of service quality			$\bar{x} \pm$ S.D.
	Good	Fair	Poor	
Overall service quality	44.4	37.0	18.5	12.84±2.18
• Reliability	51.9	40.0	8.1	3.39±0.81
• Assurance	93.3	0.0	6.7	2.89±0.48
• Tangibles	85.9	0.0	14.1	2.72±0.77
• Empathy	97.0	0.0	3.0	1.95±0.31
• Responsiveness	92.6	0.0	7.4	1.90±0.36

Most of the clients perceived that almost all service quality items met their requirements (90% and above). As a comparison only 53.3% of the clients rated the overall reputation of PHPC as good (Table 13).

Table 13 Number and percentage of service quality according to clients' Perception by item (n=135)

Service quality	Number	Percentage
Reliability		
• Good reputation	72	53.3
• Knowledgeable nurses	131	97.0
• Good supportive staff	126	93.3
• Trust in the services	128	94.8

Table 13 Number and percentage of service quality according to clients' perception by item (cont.)

Service quality	Number	Percentage
Assurance		
• Believed on the Center's program	128	94.8
• Willingness of the staff for providing the services	132	97.8
• Capability of staff	130	96.3
Tangibles		
• Signs for direction	122	90.4
• Modern equipment	122	90.4
• Convenient rooms	123	91.1
Empathy		
• Staff are willing to listen to clients' problem	131	97.0
• Staff pays attention and is interested in solving clients problem.	132	97.8
Responsiveness		
• When clients need help service is provided right away.	127	94.1
• Clients feel secure with the environment and atmosphere of the center.	130	96.3

4. Relationship between access dimension, service provision, service quality and client satisfaction

The analysis of the relationship between access dimension, service provision, service quality and clients' satisfaction was performed by Pearson's Product Moment Correlation Coefficient. A significant positive correlation exists between access dimension, service provision, service quality and clients' satisfaction (P-value =

0.000). The better the access dimension, service provision, and service quality, the higher the satisfaction. Considering the relationship between each category of access dimension, service provision, service quality and satisfaction, all categories significantly relate to satisfaction ($P < .05$) except for accessibility, reliability and empathy ($P > .05$) and results agree to hypotheses number 1, 2 and 3 (Table 14).

Table 14 Correlation coefficient between access dimension, service provision, service quality and clients' satisfaction (n=135)

Variables	Satisfaction	
	r	p-value
Access dimension	**0.325**	**0.000**
• Availability	0.295	0.000
• Accessibility	0.164	0.058
• Accommodation	0.294	0.000
• Affordability	0.168	0.050
• Acceptability	0.257	0.002
Service provision	**0.584**	**0.000**
• Equitable service	0.252	0.004
• Timely service	0.370	0.000
• Ample service	0.571	0.000
• Continuous service	0.494	0.000
• Progressive service	0.447	0.000

Table 14 Correlation coefficient between access dimension, service provision, service quality and clients' satisfaction (cont.)

Variables	Satisfaction	
	r	p-value
Service quality	**0.299**	**0.000**
• Reliability	0.168	0.052
• Assurance	0.174	0.044
• Tangibles	0.409	0.000
• Empathy	0.055	0.524
• Responsiveness	0.286	0.000

The Stepwise Multiple Regression was applied to analyse 15 selective independent variables that could best explain variation of satisfaction. The ample service was selected for the first step. It could explain 32.60% of the total variation of the clients' satisfaction. The availability and continuous service were selected for the second and the third steps which made the explanation of the variation of the clients' satisfaction increase to 34.8% and 37.6% respectively.

The relationship of these selected independent variables and satisfaction can be explained by the following equation.

Clients' satisfaction = 40.164 + 2.796 (Ample service) + 9.980 (Availability) + 9.897 (Continuous service).

It can be interpreted from the equation that the better the perception towards ample, availability and continuous services, the higher the clients' satisfaction (Table 15).

Table 15 Stepwise Multiple Regression on the selection of variables significantly related to clients' satisfaction

Step	Variable	R^2	$R^2_{Adj.}$	b	S.E. (b)	b Adjusted	P
1	Ample service	0.326	0.321	4.437	0.553	0.571	0.000
	(Constant)			60.079	12.347		0.000
2	Ample service	0.348	0.338	4.120	0.567	0.530	0.000
	Availability			8.242	3.981	0.151	0.040
	(Constant)			51.735	12.846		0.000
3	Ample service	0.376	0.362	2.796	0.777	0.360	0.000
	Availability			9.980	3.973	0.183	0.013
	Continuous service			9.897	4.057	0.236	0.016
	(Constant)			40.164	13.474		0.003

CHAPTER V

DICUSSION

The purpose of this study was to assess the client satisfaction on health promotion services of PHPC and the relationship of their perception to access dimension, service provision and service quality to overall satisfaction; and to utilize results as a means of better understanding clients' needs and expectations.

This study employed a self-administered questionnaire, as a tool to gather the data from 135 clients who attended the PHPC between February 22nd and March 31st, 1999.

Three main areas require comprehensive discussion as follows:

1. Client satisfaction on health promotion services

The overall satisfaction was moderate (56.3%), whereas 26.7% and 17.0% reached high and low level of satisfaction, respectively.

Satisfaction on Convenience: A low level of satisfaction was indicated by 17.8% of all the clients about convenience which includes the following units.

Emergency room: Client satisfaction regarding the services of this unit were low with about one third (34.8%) responding at that level. The Emergency Room in this study not only served for accidental or critical situations, but was also utilized for

doctor and client meetings. Because the overall objective of the center is to promote health, the physician often spent at least 20 minutes with each client answering questions, and giving counsel regarding sickness, health promotion and prevention of illness. Some clients took more than 20 minutes of the doctor's time. Clients were inconvenienced by having to wait long periods of time, and some even missed seeing the doctor during the time period scheduled for them. Clients felt they had wasted their time.

Physical Therapy Unit: In this unit client satisfaction was at a low level for 30.4% of the respondents. Services in this unit were planned in several stages or steps. As an example, after a steam bath, the client must take a bath and then have a body massage. This created a backlog with clients having to wait long periods of time.

At Room: The low level of satisfaction (28.8%) for client rooms was mostly due to the lack of television sets. The PHPC did not provide sets in the clients' rooms because, to promote health, they encouraged the clients to go to bed early. The only television provided was in the common room.

Swimming Pool: About one fourth (26.7%) of the clients indicated a low level of satisfaction with regard to this area. It is a popular area for pleasure, relaxation and exercise; however, seating around the pool is inadequate. Clients who could not be seated were inconvenienced. Pool staff and amenities were also felt to be lacking.

Satisfaction on Coordination: Approximately one fifth (19.3%) rated coordination among staff and service units as low. This was most likely due to poor communication among staff of the various service units. Instructions and directives

were not repeated carefully or often enough for good understanding by the clients. Close communication among unit staff would provide an understanding of processes and procedures in all the units, and thereby be transmitted clearly to the clients.

Satisfaction on Courtesy: Less than ten percent of all clients (8.1%) rated courtesy shown them at the low level. This may be due to the clients' higher expectations of the services of a private organization.

Satisfaction on Information: Roughly two fifths (41.5%) of all respondents rated Information as low. Reasons for this have to do with the lack of information they had before coming to the center. The center's budget for public relations and marketing are minimal. Also, the rural setting of the Center away from Bangkok contributes to the public's lack of awareness of the center's existence.

Satisfaction on Quality of Care: Nearly one-sixth (15.6%) of the respondents rated this as low. Clients expected quality of services to be excellent. Breakdowns in schedules or late appointments, inadequate staff, equipment and amenities lacking, insufficient information and other factors, contributed to clients opinions regarding the quality of care. Most clients were about to retire and, during their employment by the sponsoring organizations, had attended numerous seminars or conventions as part of their work responsibilities. They become bored by lectures. A simple well-run program in a good atmosphere without too many required appointments would be their preference.

From the open-ended question it was found that three-fourths of them (74.8%) would like to utilize the service at the PHPC again because of the good properties of the center such as environment, security and knowledge gained to put into practice.

Satisfaction on Cost: Roughly one quarter (24.4%) of all clients felt a low level of satisfaction because they perceived that the program was rather expensive even though most of them were sponsored by their employing organizations. From the open-ended question, it was found that only a quarter of them (24.5%) would not return to utilize the service at the PHPC due to the cost.

2. Access dimension, service provision and service quality

Access Dimension: Overall this was on a high level and all items except two show above 80%. The two below that level were accessibility and affordability.

Regarding accessibility the percentage was low (66.7%) on the convenience of transportation to the Center. This perception was probably due to the distance one must travel to arrive at the Center. It is situated in a rural, peaceful setting about two hours from Bangkok to encourage learning and the promotion of health. The travel distance also appeared to be a factor in the response regarding clients' intention to participate in the service of the PHPC in the future. One fourth of the clients (24.5%) indicated they would not come back. Written responses of these clients included distance, inconvenience, and road conditions near the center as reasons not to return.

Affordability of the program came in low for three-fourths (70.4%) of the respondents. They felt the cost of services, though they indicated them as

"reasonable," were somewhat expensive in spite of the fact that their attendance at the PHPC was paid by their employing or sponsoring organizations. They further indicated that if they had to pay for the course themselves, they would consider it too costly. The PHPC is a private, non-government facility and has no financial support other than fees charged which, to some, seemed high.

Service Provision: All but three of the items were above the 80% level. The three below that level were Reception, Physical Therapy Unit and Swimming Pool.

Within the reception services provided, only three-fourths (75.6%) of the clients felt that the telephones, fax service and computers were adequate because they compare these services to others they have experienced in hotels or other resorts.

In the Physical Therapy Unit, adequate seating for clients and adequate Staff percentages were at 80% and below. That unit was very busy due to the variety of services it rendered and was very popular with all the clients. It was not adequately furnished or staffed.

Concerning the Swimming Pool area, only three-fourths (76.3%) of the clients felt there was adequate seating around the pool. This was because many clients enjoy using the pool for swimming and exercise. Seating around that area was not sufficient to accommodate everyone.

Service Quality: The overall service quality was at a high level except for reliability. A little over half (53.3%) of the clients responded concerning the good reputation of the center. These respondents had never heard of the center before

attending. This was due to a limited budget for marketing and promotion, and therefore, the center was not well known.

3. The relationship between access dimension, service provision, and service quality according to clients' perception and clients' satisfaction.

3.1 The relationship between access dimension and clients' satisfaction

A significant positive association between access dimension and clients' satisfaction was found (P-value = 0.000). The better the perception of access dimension, the higher was the satisfaction. There were significant relationships between each of the categories of access dimension and clients' satisfaction (P<.05) except for accessibility and affordability (P>.05). This relationship went along with the concepts and the studies of Penchansky & Thomas (1989), Ross, et al. (1993), Cunningham, et al. (1995), Newbrander & Rosenthal (1997) and Salam (1998) that clients'/patients' satisfaction hinges on several dimensions. Convenience of service and access to care raises the degree of satisfaction.

3.2 The relationship between service provision and clients' satisfaction

A significant positive association between service provision and clients satisfaction was found (P-value = 0.000). The better the perception to service provision, the higher was the satisfaction. There was significant relationship between each of the categories of service provision and clients' satisfaction (P<.05). This relationship was consistent with the concept and the studies of Millett (1954), Kulathon Thanaphongthorn (1985), Ross, et al. (1993), Newbrander & Rosenthal (1997) and Boonchoo Chawchiangkhang (1998). Emphasis was made to equitable

and timely service as well as to positive inter-personal relationship with the care providers and continuous service, all of which raises clients'/patients' satisfaction level.

3.3 The relationship between service quality and clients' satisfaction

A significant positive association between service quality and clients' satisfaction was found (P-value = 0.000). The better the perception to service quality, the higher was the satisfaction. There was significant relationship between each of the categories of service quality and clients satisfaction (P<.05) except for reliability and empathy (P>.05). This relationship was consistent with the concept and the studies of Parasuraman (1986), Scardina (1994), Dulal (1997) and Newbrander & Rosenthal (1997). Each of the studies brought out a definite relationship which exists between service quality and clients' satisfaction.

4. Stepwise Multiple Regression Analysis

The result from Stepwise Multiple Regression showed that ample service, availability and continuous service were significant variables which could explain the variation of clients satisfaction at 37.6%.

CHAPTER VI

CONCLUSION AND RECOMMENDATIONS

This research was a cross sectional explanatory study aimed at assessing the client satisfaction from health promotion services of a Private Health Promotion Center and to determine the relationship between access dimension, service provision, and service quality according to clients perception and clients satisfaction. The research instrument was a structured questionnaire. The data was collected by interviewing 135 clients who attended PHPC from February 22 to March 31, 1999. The data were analysed by using percentage mean, median, Person's Product Moment Correlation Coefficient and Stepwise Multiple Regression where the significant level was set at 0.05.

CONCLUSION

The ratio of male to female clients was almost the same. They were government officials and state enterprise officers who were preparing for retirement, therefore about three-fifths were 60 years old. Most of them were bachelor degree graduates. The median of monthly income was 30,000 Baht. Reasons given for joining the PHPC's program, per the majority, was that their employers arranged it. Three-fourths of them would like to participate again in the PHPC's program.

For overall satisfaction most of the respondents indicated a moderate level of satisfaction (56.3%). Considering each component of satisfaction, clients were the most satisfied with the courtesy of the staff (47.4%) and clients satisfied at low level included information (41.5%).

For overall access dimension, 62.9% had a high level. Considering each component of access dimension most of the respondents were satisfied at high level on availability (88.1%), acceptability (84.4%) and accommodation (82.2%). The percentages were the least for accessibility (65.9%) and affordability (65.2%).

Concerning the overall service provision, only 39.3% of the respondents perceived it to be at a good level. Considering each component of service provision, the perception of most of the respondents was good for timely (89.6%), continuous (85.2%), and equitable (84.4%) services. The percentages were considerably less for progressive (59.3%) and ample (49.6%) services.

For overall service quality, 44.4% of the clients placed it at a good level. Considering each component of service quality, most of the respondents' perceptions were at a good level with regard to empathy (97.0%), assurance (93.3%), responsiveness (92.6%) and tangibles (85.9%). Only reliability (51.9%) was rather low.

There was a significant correlation between access dimension, service provision, service quality and overall client satisfaction.

The result from Stepwise Multiple Regression showed that ample service, availability and continuous service were significant variables which could explain the variation of clients' satisfaction at 37.6%.

RECOMMENDATIONS

1. **Access dimension:** Increase availability of the PHPC by providing adequate staff by service divisions with emphasis on the Physical Therapy Unit, Emergency Room and Swimming Pool. Clients are attracted to these service the most and therefore they are the most utilized. When the Center is open to services with a full quota of clients, staff from the hospital may be rotated to the Center to improve service availability. Also, sufficient equipment and amenities must become a part of the program.

2. **Improve Service Provision:** Ample and continuous services should be provided, and this again would require sufficient staff and amenities. Towels in the client rooms should be changed daily. Equipment and seating capacity surrounding the swimming pool needs to be increased. Public telephones should be provided in public areas such as the Seminar Room, Physical Therapy, Emergency Room, etc., that clients can utilize while waiting for service. As a convenience to the clients, provide health-related reading materials in areas other than just the reception area. These could include health magazines and brochures describing further the services, schedules of activities and future programs provided by the PHPC. In the Physical Therapy Unit, while clients are waiting, provide reading materials describing the therapy to be provided and explaining how the client can prevent certain body aches and pains and showing how they can personally put into practice what they are learning at the Center. Services

such as the twice-a-day walks and pool exercises should be consistently provided every day during the programs.

3. **Provide Clear Information:** Staff should be willing to answer clients' questions at all times whenever they have questions about the program. As an example, this may need to be patiently done many times during the day to explain the various steps to prepare and complete a physical therapy unit treatment. Clothing must be removed, slip into a robe, go to steam bath, then to the shower, then have the massage, etc.

4. **Public Relations and Marketing:** To enhance the public's knowledge of the PHPC, increase the public relations budget and designate a knowledgeable person to be responsible for the overall marketing. This could be a coordinated effort with the hospital's marketing department more than has existed in the past.

5. **Employee Development Plan:** Appoint a person to interact with employees to develop interpersonal relationship skills by holding pertinent seminars for the employees. Include all the staff in brainstorming sessions to put together plans for the future. When possible, bring in qualified outside persons to hold seminars to stimulate employees to a higher level of service. Send selected employees to outside seminars or courses for professional growth. Their new knowledge will contribute to further service development of the Center.

6. **Encouragement:** Encourage staff who have the knowledge and capacity to responsibly answer questions and make decision. Show appreciation to good staff and award them appropriately thus encouraging them to provide better service to the clients in the future.

7. **Cost of Service:** Routinely study ways to decrease the cost of services. Some organizations that might send their employees are unable to afford the cost. Also, some individuals might wish to attend but cannot afford it.

RECOMMENDATIONS FOR FUTURE RESEARCH

1. Study factors related to employees' work behavior such as satisfaction on providing service, motivation to work, facilities/amenities, equipment, problem and work barriers and frustrations. Results will provide ways to improve and develop satisfaction on giving service.

2. Study job satisfaction of administrator and employees with regard to how they perceive the service rendered to clients by the PHPC and whether they consider them to effective.

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APPENDIX

APPENDIX

QUESTIONNAIRE

This questionnaire is prepared only for the Private Health Promotion program thesis writing purpose. Your responses will be kept confidential and will not be exposed for any other purposes. Your cooperation in completing the questionnaire is greatly appreciated.

Serial No.....

Date..... (day/month/year)

Part I. General information of the clients

Please check (✓) the for your answers

1. Sex ○ 1. Male ○ 2. Female

2. Age.....years (Count from the last birthday)

3. Marital status

○ 1. Single ○ 2. Married

○ 3. Widowed/Divorced/Separated

4. Your highest educational status

- ○ 1. No schooling
- ○ 2. Primary school
- ○ 3. Junior high school
- ○ 4. High school
- ○ 5. Diploma
- ○ 6. Bachelor
- ○ 7. Higher than bachelor

5. Occupation

- ○ 1. No occupation
- ○ 2. Merchant
- ○ 3. Government official
- ○ 4. State enterprise employer
- ○ 5. Corporate employee
- ○ 6. General employee
- ○ 7. Other (Please specify).....

6. Monthly Salary.....Baht

7. How did you hear about our Private Health Promotion Center?

- O 1. Document from Private Health Promotion Center
- O 2. Document from other Companies
- O 3. Radio
- O 4. Television
- O 5. Newspaper
- O 6. Friends/Relatives
- O 7. Seminar
- O 8. Other (Please specify).....

8. How often have you used our service?

- O 1. First time
- O 2. More than once (Please specify number of times)...

9. The reason for using our service

- O 1. Reputation of PHPC
- O 2. Arrangement by organization
- O 3. Wish to try the program
- O 4. Others (Please specify).....

10. Will you come back to use our service again?

- ○ 1. Yes/reason.....
- ○ 2. No/reason.....
- ○ 3. Not sure/reason.....

Part II. Access dimension according to clients' perception

Please check (✓) the answer relevant to your perception

		Yes	No
11.	The services provided by the center met your needs.	O	O
12.	Convenience of facilities provided such as suitcase room, swimming-pool, rest-area, physical therapy unit are sufficient.	O	O
13.	Transportation to the Center is convenient.	O	O
14.	Length of travel time is appropriate.	O	O
15.	The time allotted for the course is appropriate.	O	O
16.	Instructions concerning use of service are clear.	O	O
17.	Cost of Services is reasonable.	O	O
18.	Cost of Services is affordable.	O	O
19.	Needed information was provided promptly and conveniently.	O	O
20.	Questions were answered promptly.	O	O

Part III. Service provision according to client's perception

Please check (✓) the answer relevant to your perception

Reception		**Yes**	**No**
21.	Reception area is adequate.	○	○
22.	Space for rest-area and luggage is adequate.	○	○
23.	Telephone, fax and computer services are sufficient.	○	○
24.	Clean drinking water is provided.	○	○
25.	Staff are warm and friendly.	○	○
26.	Assistance for handling luggage and being shown to room is available.	○	○
27.	Registration process is convenient and easy.	○	○
28.	Room accommodation is fast.	○	○

Room		**Yes**	**No**
29.	The size of the room is adequate, not too small.	○	○
30.	Convenience items such as refrigerator, drinking water and telephone are provided.	○	○
31.	Room is clean.	○	○

Seminar Room		**Yes**	**No**
32.	Ventilation is good.	O	O
33.	Lighting is adequate.	O	O
34.	Noise is limited and under control.	O	O
35.	Needed equipment is provided.	O	O
36.	Helpful staff are available.	O	O
37.	Seminars begin on time.	O	O

Cafeteria		**Yes**	**No**
38.	Seating is adequate.	O	O
39.	Ventilation is good.	O	O
40.	Eating utensils such as dishes, spoons and drinking glasses are adequate.	O	O
41.	Enough staff to provide service.	O	O
42.	Staff is Polite.	O	O
43.	Cafeteria opens on time.	O	O
44.	Queuing for service is proper.	O	O

Physical Therapy Unit		**Yes**	**No**
45.	Number of rooms is sufficient.	O	O
46.	There are enough seats for people waiting.	O	O
47.	There is enough equipment.	O	O
48.	Equipment is clean and in good condition.	O	O
49.	There are enough staff for service.	O	O
50.	Staff are helpful and eager to service.	O	O
51.	Layout and progression of service are well planned.	O	O
52.	Length of queue is appropriate.	O	O

Emergency Room		**Yes**	**No**
53.	Emergency room is well located and proper signs give directions to reach it.	O	O
54.	It is clean and hygienic.	O	O
55.	There is enough equipment.	O	O
56.	There is enough medicine.	O	O
57.	Staff is available at all times and is ready to provide service.	O	O
58.	It is adequately staffed.	O	O

Swimming pool		**Yes**	**No**
59.	It is Large enough.	O	O
60.	There are enough seats around the pool.	O	O
61.	There are enough facilities for pool usage such as a swimming pool.	O	O
62.	It is clean.	O	O
63.	There are sufficient staff/lifeguard are available.	O	O
64.	Staff is available to advise.	O	O
65.	Clean towels are provided.	O	O
66.	Regulations are posted : take off shoes and have shower before entering the pool.	O	O

Part IV. Service quality according to clients' perception

Please check (✓) the answer relevant to your perception

		Yes	**No**
67.	Came because of our reputation.	O	O
68.	Knowledgeable nurse.	O	O
69.	Good supportive staff.	O	O
70.	Trust in our service.	O	O

		Yes	No
71.	Believe that if you follow our program strictly, you will have good health.	O	O
72.	Willingness of staff at all times.	O	O
73.	Capability of staff.	O	O
74.	There are enough signs to guide for direction.	O	O
75.	The equipment is modern.	O	O
76.	Rooms are convenient and suitable for their service.	O	O
77.	Staff is willing to listen to your problems.	O	O
78.	Staff pays attention and is interested in solving your problems.	O	O
79.	When you need help, service is provided right away.	O	O
80.	Feels secure with the environment and atmosphere of the PHPC.	O	O

Part V. Levels of satisfaction towards health promotion service

Please check (✓) the answer according to the level of satisfaction

Satisfaction towards services	Level of satisfaction				
	Excellent	Good	Fair	Below average	Poor
81. Reception					
- Arrangement					
- Communication					
- Personnel, Staff					
- Processing of service					
82. Room					
- Hygienic					
- Amenities					
83. Seminar Room					
- Convenient					
- Ventilated					
- Amenities					

Satisfaction towards services	Level of satisfaction				
	Excellent	Good	Fair	Below average	Poor
84. Cafeteria					
- Hygienic					
- Ventilated					
- Amenities					
- Punctual time of service, opening and closing					
85. Physical Therapy Unit					
- Treatment rooms					
- Hygienic					
- Amenities					
- Staff					
- Processing of service					
86. Emergency Room					
- Prompt services					
- Equipment					
- Staffs					

Satisfaction towards services	Level of satisfaction				
	Excellent	Good	Fair	Below average	Poor
87. Swimming Pool					
- Hygienic					
- Amenities					
- Staff					
- Regulations for uses of pool					
88. Staff Teamwork					
89. Coordination among units					
90. Manner of staff					
91. Friendliness of staff					
92. Staff pays full attention to you					
93. Staff provides clear information					
94. Information provided to public and your organization.					
95. Documents and advice from the PHPC.					
96. Service is convenient and prompt.					

Satisfaction towards services	Level of satisfaction				
	Excellent	Good	Fair	Below average	Poor
97. Service is on time.					
98. Service is consistent, for example, regular exercise.					
99. Activities provided are consistent with the whole program.					
100. Services are worth the price you paid.					

BIOGRAPHY

NAME	Ms. Sureeporn Ponsode
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PLACE OF BIRTH	Bangkok, Thailand
INSTITUTIONS ATTENDED	Bangkok Adventist School of Nursing 1982-1986 : Certificate of Diploma in Nursing and Midwifery Mahidol University, 1986-1988: Bachelor of Nursing (major of Medical Nursing) Mahidol University, 1997-2000: Master of Science (Health Administration)
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