PATIENT SATISFACTION OF HEALTH SERVICE DELIVERY IN PRIMARY HEALTH CENTRES: A SOCIO-DEMOGRAPHIC STUDY

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ABSTRACT

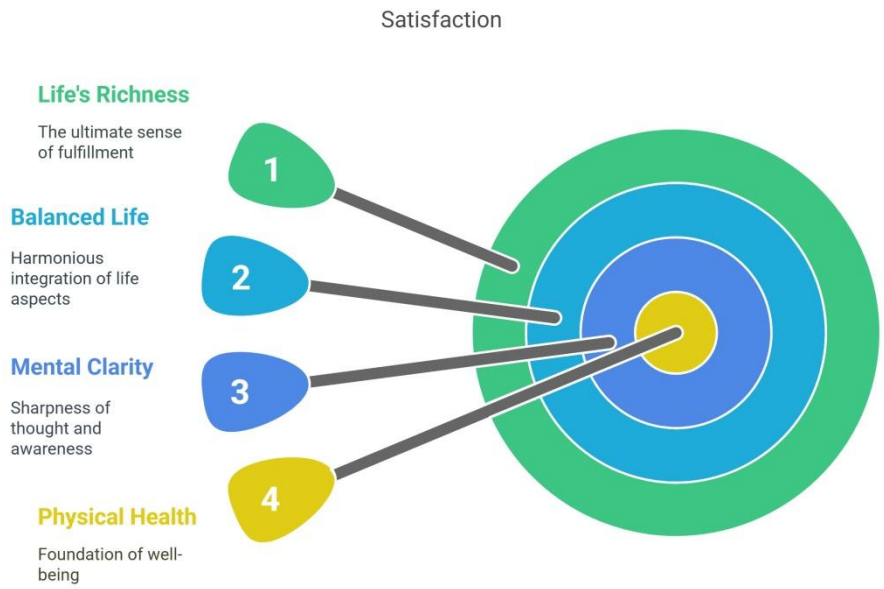
With the Increase in the number of hospitals and Information technology advancement in Health care. Patient satisfaction serves as a critical indicator of healthcare quality, influencing service utilization and health outcomes. There are various studies on other product related and service oriented to know the perceptions and satisfaction of customers. The present study focused on 410 patients from PHCs in Jogulamba Gadwal district were surveyed using a structured questionnaire covering aspects such as waiting time, staff behavior, cleanliness, availability of medicines, and overall experience. Statistical techniques including frequency analysis and chi-square tests were employed to assess patterns and relationships. The findings reveal significant variation in satisfaction levels across different socio-demographic groups, such as age, gender, education, and income. The study highlights the need for targeted interventions to improve patient experiences and calls for more inclusive, responsive healthcare services at the primary level.

KEY WORDS: *Health care; PHC's ; Health Quality; • Rural Healthcare and Health Service Delivery*

INTRODUCTION

Health is widely acknowledged as a fundamental human right, prompting governments globally, including India, to prioritize equitable healthcare access by strengthening primary health care (PHC) systems. The Alma-Ata Declaration underscored the principle of "Health for All" through Primary Health Care, emphasizing the importance of social justice, equity, and community involvement. However, health systems still face ongoing challenges such as persistent disparities, fragmented service delivery, and growing public dissatisfaction. Patient satisfaction is an important way to measure the quality of healthcare. Age can influence how people view their care. Older adults often report higher satisfaction because they may have lower expectations, more appreciation for care, or more regular interactions with doctors. In contrast, younger people may expect better communication and digital services, leading to lower satisfaction if these are lacking. To improve satisfaction, healthcare providers should understand and respond to the needs of different age groups.

This study investigates patient satisfaction in relation to various personal, social, economic, and demographic factors within the Jogulamba Gadwal district of Telangana, a rural area characterized by limited healthcare resources and a diverse population that heavily depends on PHCs.



REVIEW OF LITERATURE

Parasuraman et al. (1988) developed the SERVQUAL model to evaluate service quality by identifying the gap between patient expectations and their actual healthcare experiences. The model is built on five key dimensions: tangibles, reliability, responsiveness, assurance, and empathy. It is widely adopted in Indian healthcare studies, particularly in assessing the quality of services offered at Primary Health Centres (PHCs). Using quantitative survey methods, researchers analyze how each dimension influences patient satisfaction. The model has proven especially useful in rural or underserved areas of India, where disparities between service quality and expectations are more pronounced, and helps identify areas needing improvement to meet patient demands.

Donabedian (1988) proposed the Quality of Care Framework, which categorizes healthcare quality into three elements: structure (e.g., physical facilities and staff), process (e.g., interactions during service delivery), and outcomes (e.g., health improvements). This framework is particularly relevant for evaluating PHCs in India, where issues in infrastructure, human resources, and service procedures often impact patient satisfaction. Researchers apply this model using mixed methods such as facility audits and patient interviews to understand how each component contributes to the quality of care. The model emphasizes that improving both infrastructure and service delivery processes can significantly enhance overall patient satisfaction and health outcomes.

Rosenstock et al. (1974) introduced the Health Belief Model (HBM) to explain why individuals seek or avoid healthcare based on their beliefs about health conditions. The model focuses on factors such as perceived susceptibility, severity, benefits, and barriers to care. In the Indian PHC context, the HBM has been instrumental in explaining health-seeking behavior, particularly in rural areas where cultural beliefs and low health literacy influence decisions. Researchers using interview-based surveys have found that patients' expectations,

fears, and understanding of illness greatly impact their satisfaction with services. The model helps clarify why some patients delay or avoid care, thereby affecting satisfaction outcomes.

Oliver (1980) developed the Expectancy-Disconfirmation Theory, which links satisfaction to the difference between what patients expect and what they actually experience. If healthcare services meet or exceed expectations, satisfaction is high; if they fall short, dissatisfaction occurs. This theory is widely applied in PHC studies in India, where issues such as long waiting times, lack of medications, and poor communication frequently lead to unmet expectations, despite technically sound medical care. Researchers often use structured questionnaires to measure expectation vs. experience, and the findings support the idea that managing patient expectations is critical to improving satisfaction levels.

Andersen (1995) proposed the Behavioral Model of Health Services Utilization, which explains healthcare use and satisfaction through predisposing factors (age, education), enabling factors (income, access), and need factors (perceived or actual illness). This model has been extensively applied in India to understand disparities in access to and satisfaction with PHC services. Quantitative studies often use statistical tools like logistic regression to measure how these factors influence health service utilization. Findings suggest that patients from marginalized groups often face structural and economic barriers, leading to reduced satisfaction, highlighting the need for more inclusive and accessible healthcare policies.

Kumar et al. (2020) conducted a study on patient satisfaction in government-operated allopathic healthcare facilities in Lucknow, India. The research aimed to evaluate patient experiences related to care quality, staff professionalism, and facility infrastructure in Primary Health Centres (PHCs). Using descriptive methods and patient feedback, the study found that dissatisfaction was largely due to prolonged waiting times, lack of follow-up care, and perceived impersonal staff attitudes. It concluded that enhancing systematic follow-up protocols and improving communication and empathy from healthcare providers could significantly raise satisfaction levels. The study recommends that health systems focus on provider-patient interaction quality to build patient trust and engagement.

Mallya et al. (2021) investigated patient satisfaction with primary healthcare services in the Shivamogga district of Karnataka, focusing on the quality of medical care and service delivery processes. Through structured surveys and field observations, the study found that while patients appreciated the affordability and accessibility of PHCs, they raised concerns regarding the availability of medications, staff proficiency, and facility cleanliness. The findings emphasize the negative impact of resource limitations and highlight the need for improved drug supply chains, better sanitation, and continued staff training. The study advocates for structured interventions to enhance service delivery, which would subsequently improve overall satisfaction.

Mishra et al. (2019) explored patient satisfaction in rural India, with a focus on identifying key factors affecting satisfaction with primary healthcare services. Using a cross-sectional survey design, the study found that patients were generally satisfied with basic healthcare access, but dissatisfaction stemmed from limited diagnostic services and long waiting times.

The authors concluded that the lack of diagnostic infrastructure weakens the effectiveness of PHCs and reduces patient confidence in care. The research suggests that upgrading diagnostic capabilities and ensuring timely service are essential strategies to improve patient satisfaction in rural healthcare settings.

Mohan et al. (2018) assessed patient satisfaction in rural Tamil Nadu, aiming to understand the factors driving satisfaction and dissatisfaction in PHCs. The study employed patient interviews and service evaluations, revealing that while accessibility and affordability were strong points, dissatisfaction arose from poor privacy during consultations, extended waiting periods, and inadequate follow-up care. The findings highlight the importance of maintaining confidentiality, reducing wait times, and establishing continuity of care to improve patient experience. The study concludes that PHCs must focus on building trust and addressing patient concerns more holistically to enhance satisfaction and service utilization.

OBJECTIVES

- To assess the level of patient satisfaction at primary health care centers in the Jogulamba Gadwal district
- To examine the influence of personal, social, economic, and demographic factors (age, gender, education, monthly income, religion, occupational status, marital status, caste health status, utilization of health services and Satisfaction.
- To analyse the association between various independent variables (age, gender, education, monthly income, religion, occupational status, marital status, caste, health status and satisfaction.

Methodology

The present study is based on the data collected from the respondents (patients) of jogulamba Gadwal district of telangana. Interviewing method was used for data collection. Researcher filled the interview schedule in a face to face interview. The interview schedule consist of two parts A and B. Part A pertaining to questions regarding independent variables, part B consist of standardized scale to measure the patient satisfaction.

The collected data tabulated and transferred to SPSS. The data was analysed using statistical tests. These tests are Range, percentage, Quartiles and chi-Squair analyses were carried out. The results were summarized and presented.

PATIENT SATISFACTION WITH SOCIO- ECONOMIC VARIABLES

Patient Satisfaction

S. No	Level of Satisfaction (Scores)	No. of Respondents	Percentage
	Low (42 – 52)	217	52.9
	Moderate (53 – 39)	99	24.1

	High (60 – 72)	94	22.9
	Total	410	100

As per above table majority (52.9 percent) of the respondents are fully satisfied and said that they have always received required medical help and services in time. Only a little less than quarter (24.1 percent) respondents were said that they are satisfied sometimes only compared to the total number of services and medications they received followed by less than quarter (22.9 percent) respondents expressed they are never satisfied with the services they have received.

Socio Demographic Variables in Patient satisfaction

The above principles are effected by a range of factors first one expectations of care, second one relation with staff and physician or doctor or third one responsiveness of staff and fourth one cleanliness fifth one pain management sixth one attire finally follow up care and support to patient in main factor for patient satisfaction.

Gender also affects satisfaction. Studies show that women often report slightly lower satisfaction than men. This may be because women value emotional support and communication more, while men focus on treatment results and efficiency. Women are also more likely to express dissatisfaction if their needs are not met. By recognizing these differences, healthcare providers can offer more personalized and effective care.

Education level plays a role too. People with higher education are more involved in decisions about their health and may expect clearer communication. If their expectations are not met, they may feel dissatisfied. On the other hand, people with less education may trust doctors more and have lower expectations, leading to higher satisfaction. Adjusting communication to match patients' educational levels can help improve satisfaction.

Occupation influences what patients expect. Employed people, especially professionals, may want quick and personalized care. If the service is slow or unclear, they may feel dissatisfied. Retired or unemployed individuals may focus more on the doctor's interaction and availability. Understanding these differences helps healthcare workers deliver care that fits patients' daily lives.

Monthly income is another key factor. People with higher incomes have more access to healthcare and higher expectations. If those expectations aren't met, they may report lower satisfaction. Those with lower incomes may have fewer options but may still feel satisfied if their basic needs are met. However, they can also feel dissatisfied if costs prevent them from getting needed care. Health systems should consider income levels when designing services to ensure fair access and satisfaction.

Marital status affects satisfaction too. Married people usually feel more satisfied with care because they have emotional and practical support from their partners. This support helps

them follow treatment plans and communicate better with doctors. Single, divorced, or widowed individuals may feel lonely or anxious, which can lower their satisfaction. Recognizing these differences allows providers to offer more supportive care.

Religion shapes patient satisfaction by influencing values and expectations. Many patients want their spiritual needs respected in healthcare settings. When doctors respect religious practices—like prayer, diet, or end-of-life beliefs—patients feel more understood and satisfied. Ignoring these needs can cause dissatisfaction, even if the treatment is good. Including religious sensitivity in care builds trust and improves the patient experience.

Caste, especially in societies where it still affects social status, can also influence satisfaction. People from lower caste groups may face discrimination in healthcare, leading to poor experiences even when care quality is good. In contrast, higher caste patients might receive better treatment and feel more respected. These inequalities can reduce trust and satisfaction for marginalized groups. To improve satisfaction fairly, healthcare workers must treat all patients with equal respect and cultural understanding, regardless of caste.

Demographic Description of Respondents

Factor	Category	Low	Moderate	High
Age	17–29 Years	46.15	28.40	25.44
	30–45 Years	60.12	17.72	22.15
	46–77 Years	53.01	27.71	19.27
Gender	Male	50.65	23.14	26.20
	Female	55.80	25.41	18.78
Education	Illiterate	59.25	28.70	12.03
	Up to SSC	20.40	0.00	79.59
	Inter / Degree / Professional	54.48	25.51	20.00
Occupation	Housewife / Student	60.00	31.66	08.33
	Unemployed	51.59	09.04	39.36
	Agricultural Labour	30.30	56.56	13.13
	Self-employed	85.71	11.11	03.17
Monthly Income (₹)	1,000 – 6,000	56.29	02.22	41.48
	6,001 – 12,000	34.10	46.24	19.65
	12,001 – 18,000	80.39	15.68	03.92
Marital Status	Married	50.44	24.47	25.07
	Unmarried	57.37	26.22	16.39
	Widowed / Divorced	92.85	07.14	00.00
Religion	Hindu	52.84	23.57	23.57

	Muslim	58.82	17.64	23.52
	Christian	50.00	37.50	12.50
Caste	Scheduled Caste	71.55	21.55	06.89
	Scheduled Tribe	20.00	20.00	60.00
	Other Backward Class (OBC)	46.02	25.25	28.71

The study on patient satisfaction of health service delivery in Primary Health Centres shows that socio-demographic factors play a crucial role. Middle-aged patients (60.12%) reported the highest low satisfaction, followed by older adults (53.01%), while younger patients had slightly better satisfaction (25.44% high). Females (55.80%) showed more dissatisfaction than males (50.65%), indicating gender-based differences. Patients educated up to SSC reported the highest high satisfaction (79.59%), while illiterate (59.25%) and highly educated (54.48%) individuals had more dissatisfaction. The unemployed group had the highest high satisfaction (39.36%), while self-employed individuals (85.71%) showed the most dissatisfaction. People with low income (₹1,000–6,000) had 41.48% high satisfaction, whereas those in the higher income group (₹12,001–18,000) reported 80.39% low satisfaction. Married patients (25.07%) experienced more satisfaction than widowed/divorced (92.85% low). Scheduled Castes (71.55%) were the most dissatisfied, while Scheduled Tribes had the highest high satisfaction (60%). Religious differences were minimal, but Muslims (58.82%) reported slightly higher dissatisfaction. Overall, the study suggests the need for targeted, inclusive, and socially sensitive healthcare approaches to enhance satisfaction across diverse demographic groups.

HYPOTHESIS TESTING

		Chi Square Value	df	p Value
1	Age and Patient Satisfaction	8.408	4	0.78
2	Gender and Patient Satisfaction	3.147	2	0.207
3	Education and Patient Satisfaction	105. 635	4	0.000
4	Occupational Status and Patient Satisfaction	132.278	6	0.000
5	Monthly Income and Patient Satisfaction	128.437	4	0.000
6	Marital Status and Patient Satisfaction	11.655	4	0.020
7	Religion and Patient Satisfaction	3.479	4	0.481
8	Caste and Patient Satisfaction	31.968	4	0.000

The Chi-square test results indicate that socio-demographic variables have a significant association with patient satisfaction in Primary Health Centres. A highly significant relationship was observed for education ($\chi^2 = 105.635$, $p = 0.000$), occupational status ($\chi^2 = 132.278$, $p = 0.000$), monthly income ($\chi^2 = 128.437$, $p = 0.000$), and caste ($\chi^2 = 31.968$, $p = 0.000$), as their p-values are less than 0.05, indicating a strong influence on satisfaction

levels. Marital status ($\chi^2 = 11.655$, $p = 0.020$) also showed a statistically significant relationship, though to a lesser degree. In contrast, age ($\chi^2 = 8.408$, $p = 0.78$), gender ($\chi^2 = 3.147$, $p = 0.207$), and religion ($\chi^2 = 3.479$, $p = 0.481$) did not show significant associations, as their p-values exceed 0.05, suggesting that these factors do not significantly affect patient satisfaction in this context. These results highlight the need for targeted improvements based on education, employment, income, caste, and marital status to enhance healthcare experiences in PHCs.

CONCLUSION

In the presents study, descriptive survey design was used. Accordingly this research describes the patient satisfaction levels in select PHCs. Patients who attended these centers on three constitutive days were included in the study. From the data higher satisfaction levels are more common among individuals with higher education (especially "Up to SSC") and those in the Scheduled Tribe caste. Low satisfaction is notably higher among self-employed individuals, widowed/divorced persons, and those with higher income brackets. Moderate satisfaction is prevalent among agricultural laborers and middle-income groups. Socio-economic and demographic factors show varying influence on patient satisfaction levels. It is observed that education, occupation, income, marital status, and caste have a significant impact on patient satisfaction. In contrast, age, gender, and religion do not appear to significantly influence satisfaction levels among patients.

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