Contents lists available atIOCS

Science Midwifery

journal homepage:www.midwifery.iocspublisher.org

Outpatient satisfaction with the integration of primary health care services: A comparative study in Gowa Regency

Andi Afriyani Safitri[1], Fais Satrianegara[2], Fatmawaty Mallapiang[3]

[1]Master's Program in Public Health, Postgraduate School, Universitas Islam Negeri Alauddin Makassar, Indonesia

[1]RSUD Kelas D Pratama Kabupaten Gowa, Indonesia

[2,3]Department of Public Health, Faculty of Medicine and Health Sciences, Universitas Islam Negeri Alauddin Makassar, Indonesia

ARTICLE INFO

Article history:

Received Apr 6, 2026
Revised Apr 13, 2026
Accepted Apr 23, 2026

Keywords:

Comparative Study
Healthcare Integration
Outpatient Satisfaction
Primary Health Care
Service Quality

ABSTRACT

The implementation of Primary Healthcare Integration aimed to address service fragmentation and improve the quality of health services in Indonesia. This study evaluated outpatient satisfaction with the integrated system compared to a conventional service model in Gowa Regency. A quantitative comparative research design was employed, involving 100 respondents from a health center implementing the integration and 97 respondents from a health center using the conventional model. Data were collected through questionnaires measuring five dimensions of service quality: reliability, responsiveness, assurance, empathy, and tangibles. Statistical analysis using the Mann-Whitney U test revealed a significant difference in satisfaction levels between the two groups ($p < 0.001$). The integrated system group showed a substantially higher mean rank of 144.08 compared to 52.53 in the conventional group. High satisfaction levels were observed across all dimensions in the integrated system, particularly in the empathy and tangible aspects. It was concluded that the lifecycle-based cluster approach within the integrated system significantly enhanced patient experience and satisfaction. These findings suggested that the transformation of primary health services effectively met community expectations and provided a more structured healthcare delivery model.

Corresponding Author:

Andi Afriyani Safitri,
Master's Program in Public Health,
Universitas Islam Negeri Alauddin Makassar,
Jl. H. M. Yasin Limpo No. 36, Desa Romang Polong, Kabupaten Gowa, Sulawesi Selatan, 90245, Indonesia
Email: andiafriyanis@gmail.com

INTRODUCTION

Primary health care services constitute the main foundation of the national health system in Indonesia, designed to ensure access to quality services for all segments of society. *Puskesmas* (Community health centre), as the frontline providers, play a crucial role in integrating promotive, preventive, curative, and rehabilitative efforts to achieve the targets of the Sustainable Development Goals (SDGs, 2023). However, significant challenges have emerged due to the low

achievement of Minimum Service Standards (SPM) during the 2021–2023 period, where service coverage for the productive age population, the elderly, and patients with hypertension and diabetes mellitus remains far below the 100% target. Low SPM achievements are not merely statistical failures but empirical evidence that the previous disease centered model failed to foster sufficient healthcare seeking behavior among the population. This condition is further exacerbated by the increasing prevalence of non-communicable diseases (NCDs), such as hypertension, which reached approximately 38% in 2023 and is often undiagnosed due to low public awareness of screening (Wisni et al., 2025).

In response to these challenges, the government introduced a strategic policy through Keputusan Menteri Kesehatan (the Decree of the Minister of Health) Number HK.01.07/MENKES/2015/2023 concerning Technical Guidelines for the Integration of Primary Health Care Services (ILP) (Kemenkes RI, 2023). This policy shifts the service paradigm from a program or disease-based approach to a life cycle-based approach, covering pregnant women, children, adolescents, adults, and the elderly. The ILP aims to reduce service fragmentation and duplication of visits, which have been longstanding barriers to resource efficiency in *Puskesmas*. Nevertheless, the implementation of ILP faces various field challenges, including limited availability of trained medical personnel, inadequate infrastructure, and the need for policy harmonization between central and local governments (Husain et al., 2025; Mait et al., 2025; Zamzami & Jais, 2026).

Service quality in this policy transition becomes a vital indicator that must be measured through patient satisfaction levels. Satisfaction is not merely a perception but a fundamental right of patients to receive high quality and responsive services. Comprehensive measurement of satisfaction includes five main dimensions including reliability, responsiveness, assurance, empathy, and tangible (Sianturi et al., 2025; Wu et al., 2021). Regular evaluation of these dimensions is essential to provide feedback for improving the service system and enhancing public trust in primary health care facilities (Meriam et al., 2025).

While previous studies on health service quality in Indonesia have extensively explored general patient satisfaction, they often focused on traditional disease-based service models. The novelty of this study lies in its specific focus on the fundamental structural shift from disease centric to life cycle-based clusters under the newly implemented ILP policy. By utilizing a comparative design between a pilot ILP health center (Puskesmas Bontomarannu) and a conventional model health center (Puskesmas Parangloe), this research provides a direct performance benchmark that is currently absent in existing literature. This study does not merely measure satisfaction scores but evaluates how a systemic architectural change in primary care affects the five dimensions of service quality during a critical transition period. The results are expected to offer empirical evidence for policymakers to refine the national scale-up of the ILP initiative, particularly in the context of Gowa Regency.

RESEARCH METHOD

This study employed a comparative quantitative design using a two-group control design (Hanaruddin, 2021), to compare patient satisfaction levels across two different healthcare facility groups. The first group consisted of *Puskesmas* Bontomarannu as a representation of a facility that has implemented the ILP policy, while the second group was *Puskesmas* Parangloe, which has not implemented the policy (Non-ILP). The study was conducted in Gowa Regency, South Sulawesi, from July to August 2025.

The study population included all outpatient patients within the last three months, comprising 11,865 patients at *Puskesmas* Bontomarannu and 2,806 patients at *Puskesmas* Parangloe. The sample size was determined using the Slovin formula (Hidayat, 2017), with a margin of error of 10%, resulting in 100 respondents from *Puskesmas* Bontomarannu and 97 respondents from *Puskesmas* Parangloe.

The sampling technique applied was purposive sampling, chosen specifically to ensure that the respondents selected were those who had directly experienced the clinical pathways of the ILP clusters (in the intervention group) or the general outpatient clinics (in the control group). To maintain sample representativeness and minimize selection bias, the selection process strictly adhered to criteria that reflected the demographic and clinical diversity of the population, as follows: (a) patients or family members willing to participate as respondents, (b) individuals who had received outpatient services within the last three months, (c) aged over 17 years or represented by a guardian for paediatric patients, and (d) those who received services within the ILP cluster or general outpatient clinic. The exclusion criteria included visitors with no direct involvement in the service clusters and individuals who were unwilling to complete the questionnaire.

The research instrument was a structured questionnaire distributed both directly and via Google Forms. The questionnaire measured five dimensions of service quality (reliability, responsiveness, assurance, empathy, and tangibles) using a 5-point Likert scale, ranging from 1 (Very Dissatisfied) to 5 (Very Satisfied). The collected data underwent several processing stages: (a) editing to ensure completeness, (b) coding to convert narrative data into numerical form, (c) data entry into statistical software (SPSS 30.0), and (d) data cleaning to ensure the accuracy of data input.

Data analysis was conducted in two stages. First, descriptive analysis was used to present the frequency distribution of respondent characteristics and satisfaction levels in each community health centre. Second, hypothesis testing was performed to examine differences in mean satisfaction between the two groups using the non-parametric Mann–Whitney U test, with a significance level of $p < 0.05$.

RESULTS AND DISCUSSIONS

This study involved a total of 197 respondents, consisting of 100 patients from *Puskesmas* Bontomarannu (ILP group) and 97 patients from *Puskesmas* Parangloe (Non-ILP group). Data analysis began with a description of respondent characteristics as presented in Table 1.

Table 1. Characteristics of respondents

Characteristics	ILP (n=100)	Non-LP (n=97)
Gender		
Male	37 (37%)	34 (35.1%)
Female	63 (63%)	63 (64.9%)
Education		
Primary	7 (7%)	14 (14.4%)
Junior High School	30 (30%)	33 (34.0%)
Senior High School	53 (53%)	38 (39.2%)
Diploma/Bachelor's	10 (10%)	12 (12.4%)
Income		
≤1.5jt IDR	93 (93%)	73 (75.3%)
>1.5jt IDR	7 (7%)	24 (24.7%)

Data in Table 1 indicate that the majority of respondents in both *Puskesmas* were female, had a senior high school level of education, and earned less than 1.5 million Indonesian Rupiah per month. The predominance of female respondents (63.0% in Bontomarannu and 64.9% in Parangloe) aligns with global and national trends in the utilization of primary healthcare facilities. Women tend to exhibit higher health seeking behaviour compared to men. Socioculturally, women often act as health managers within the family, bearing responsibility for the health of children and other family members. This finding is supported by Astuti (2026), who states that women are more sensitive to health complaints and more proactive in seeking medical care. Furthermore, Maryuni (2024) emphasizes that the higher rate of female visits is associated with the reproductive cycle and caregiving roles, which increase their exposure to services at community health centres.

The education level, predominantly senior high school graduates (53.0% and 39.2%), indicates that the target group possesses a sufficient level of health literacy to understand service procedures. Education is a predisposing factor that influences an individual's perception and expectations regarding service quality. Respondents with secondary education generally have a more critical ability to evaluate service quality dimensions such as reliability and responsiveness of healthcare providers. As stated by Sembiring et al. (2025), education level is positively correlated with awareness of patient rights. In the context of ILP, this group is more adaptable to changes in cluster-based service delivery due to their better capacity to absorb procedural information.

The proportion of respondents with income levels below 1.5 million Indonesian Rupiah (93.0% and 75.3%) confirms that *Puskesmas* serve as the primary healthcare providers for lower to middle income populations in Gowa Regency. This group is highly vulnerable to catastrophic health expenditures, making the availability of integrated and free primary care services critically important. The ILP policy, which aims to simplify access and improve service flow efficiency, provides indirect economic benefits to respondents by reducing opportunity costs associated with shorter waiting times. This finding is consistent with the Ministry of Health of the Republic of Indonesia Kemenkes RI (2023) in the ILP Technical Guidelines, which emphasize that primary healthcare transformation aims to ensure equitable access to quality health services for all segments of society without financial barriers. Subsequently, a comparative analysis of patient satisfaction based on the five dimensions of service quality was conducted, as presented in Table 2.

Table 2. Comparison of patient satisfaction dimensions

Dimension	Category	ILP (Puskesmas Bontomarannu)	Non-ILP (Puskesmas Parangloe)	*p-value*
Reability	Satified	82 (82%)	2 (2.1%)	0.001
Responsiveness	Satified	85 (85%)	14 (14.4%)	<0.001
Assurance	Satified	79 (79%)	10 (10.3%)	<0.001
Empathy	Satified	89 (89%)	10 (10.3%)	<0.001
Tangible	Satified	89 (89%)	2 (2.1%)	<0.001

Based on Table 2, the analysis reveals a striking contrast in satisfaction levels across all five service quality dimensions between the ILP group at *Puskesmas* Bontomarannu and the Non-ILP group at *Puskesmas* Parangloe. Overall, the percentage of satisfied patients in the ILP group substantially exceeded that of the Non-ILP group across every assessed dimension. In terms of reliability, the ILP group recorded a satisfaction rate of 82.0%, compared to only 2.1% in the Non-ILP group. Statistical testing yielded a p-value of 0.001, indicating a highly significant difference. This finding suggests that the ILP system is perceived as considerably more reliable in delivering accurate and trustworthy services. The superiority of ILP in this dimension lies in its provision of more precise and dependable care through a life cycle cluster-based division of labour. Within the ILP framework, patients are served by dedicated medical teams assigned to specific age groups, thereby reducing the risk of procedural errors. This is consistent with the findings of Wida & Ida (2023), who emphasized that the accuracy of healthcare providers in service delivery is a primary determinant of patient satisfaction. The extreme dissatisfaction observed at the Non-ILP facility reflects patients' scepticism toward the reliability of a system that remains fragmented in its service structure.

Regarding responsiveness, the ILP group achieved a satisfaction rate of 85.0%, in stark contrast to only 14.4% in the Non-ILP group, with a p-value of <0.001. This finding demonstrates that healthcare providers operating under the ILP system are considerably prompter and more responsive in addressing patient needs. The streamlined service flow inherent to the ILP model enables staff to act more swiftly and efficiently. Through cluster-based task allocation, workloads are more evenly distributed among personnel, resulting in reduced patient waiting times. As noted by Anisah et al. (2022), responsiveness exerts a significant influence on perceived service quality, as patients feel their concerns are heard and addressed in a timely manner. Conversely, in the Non-

ILP system, convoluted service pathways frequently generate negative perceptions regarding the speed of care delivery.

With respect to the assurance dimension, satisfaction rates stood at 79.0% for the ILP group and 10.3% for the Non-ILP group, with p<0.001, confirming that the difference remains statistically significant. Assurance pertains to the competence and courtesy of healthcare personnel in fostering a sense of security among patients. Within the ILP framework, standardized service protocols across each cluster provide patients with a degree of both legal and medical certainty. Permana et al. (2023) identified safety assurance and trust in medical personnel as key variables influencing satisfaction among both inpatient and outpatient populations. The presence of competent medical staff within each ILP cluster instils confidence in patients regarding their prospects for recovery.

The empathy dimension recorded the highest satisfaction level among ILP group patients, reaching 89.0%, affirming that the cluster-based service approach under ILP can deliver more personalized attention to patients. The life cycle cluster model encompassing maternal and child health, adult care, and geriatric services enables healthcare providers to adopt a more individualized approach and respond to the specific needs of each age group. This corroborates the findings of Khairani et al. (2021), who identified empathy as the dimension with the greatest impact on patient satisfaction, given its psychological dimension. Through ILP, the interaction between healthcare providers and patients transcends a purely transactional medical encounter, evolving into a more holistic and attentive form of care.

The tangibles dimension, which relates to facilities and infrastructure, shows that the ILP group achieved a satisfaction rate of 89.0%, compared to only 2.1% in the Non-ILP group, with a p-value of <0.001. This finding reflects that the organization of physical facilities within the ILP system provides greater comfort for patients. The arrangement of facilities based on cluster segmentation enhances both convenience and ease of navigation (Fatimah, 2023). In addition, the neat appearance of healthcare providers and the availability of modern supporting facilities within the ILP system serve as tangible evidence of service quality. This finding is consistent with Sugondo et al. (2021), who state that cleanliness and comfort of physical facilities are the first aspects perceived by patients and play a crucial role in shaping initial satisfaction before the treatment process begins.

Overall, all service quality dimensions demonstrated p-values of <0.05, indicating that the null hypothesis is rejected. It can therefore be concluded that the implementation of the ILP policy significantly improves patient satisfaction across all service dimensions compared to the conventional service system (Non-ILP), reflecting the success of the first pillar of health transformation initiated by the Ministry of Health of the Republic of Indonesia Kemenkes RI (2023). The integration of primary healthcare services has proven not only to simplify service processes but also to fundamentally transform public perceptions of the quality of healthcare services.

Table 3. Overall comparison of patient satisfaction

Group	N	Mean Rank	*p-value*
ILP	100	144.08	<0.001
Non-ILP	97	52.53	
Total	197		

Based on Table 3, the Mann-Whitney test yielded a significance value of <0.001 ($p < 0.05$), confirming a statistically significant difference in patient satisfaction levels between the *Puskesmas* implementing the ILP system and the Non-ILP *Puskesmas*. The substantive significance of the nearly threefold disparity in Mean Rank scores between the ILP and Non-ILP groups (144.08 vs 52.53) indicates more than just a statistical preference; it reflects a profound paradigm shift in healthcare delivery. This vast gap signifies that the conventional, fragmented service model (Non-ILP) is increasingly perceived as inadequate by the community, failing to meet modern standards

of patient-centered care. Substantively, this suggests that the transition to a life cycle-based cluster system has successfully addressed the trust deficit in primary care. By integrating services, the ILP model moves beyond clinical efficiency to restore humanistic value in healthcare, where patients no longer feel like cases to be processed, but individuals whose health needs are understood within their specific life stages. Furthermore, this wide satisfaction gap serves as an empirical justification for an urgent and comprehensive national scale up of the ILP policy, as maintaining the Non-ILP model may lead to continued public disengagement and lower utilization of essential primary health services. These results demonstrate that the implementation of the Primary Care Integration policy has made a positive contribution to improving outpatient satisfaction in Gowa Regency. The notably wide disparity in scores indicates that the transformation of primary care services through a life cycle cluster approach is more readily accepted by the community and delivers a markedly superior service experience (Anjara et al., 2019).

The significant advantage observed in the ILP system can be attributed to a fundamental paradigm shift from a program- or disease-based service model to a life cycle cluster approach. In the conventional (Non-ILP) system, services tend to be fragmented, requiring patients to move between different counters or polyclinics for varying needs, which frequently results in confusion and prolonged waiting times. In contrast, the ILP system integrates services encompassing maternal and child health, productive-age care, and geriatric services within a single coordinated cluster. This is aligned with the Ministry of Health of the Republic of Indonesia Kemenkes RI (2023) in the ILP Technical Guidelines, which stipulates that integration is intended to simplify service pathways and ensure that everyone receives a comprehensive healthcare package appropriate to their stage of life within a single visit. Furthermore, the stark disparity in scores suggests that the community is more receptive to a structured and integrated service model. As argued by Ulfah (2025), the success of ILP is highly contingent upon the establishment of a more linear workflow, which ultimately minimizes duplicative visits and resource inefficiency. The high satisfaction levels recorded at ILP-implementing *Puskesmas* reflect the system's capacity to meet patient expectations for more efficient and well-organized care.

From a service quality perspective, this transformation encompasses comprehensive improvements across all SERVQUAL dimensions reliability, responsiveness, assurance, empathy, and tangibles (Sepriano et al., 2025; Tripathi & Siddiqui, 2020; Upadhyai et al., 2019). The nearly threefold difference in Mean Rank underscores that the ILP system represents far more than an administrative reorganization; it constitutes a substantive enhancement in the overall quality of care delivered. This finding is corroborated by Andrianto et al. (2025), who reported that service integration at primary healthcare facilities significantly improves patient loyalty and positive perceptions, attributable to greater clarity in service pathways and more focused staff competency. In terms of policy implications, the findings of this study send a strong signal to policymakers in Gowa Regency to urgently pursue the replication of the ILP system across all *Puskesmas*. The substantial satisfaction gap documented in this study demonstrates that the Non-ILP system is no longer adequate in meeting minimum service standards nor the expectations of a contemporary community that demands primary healthcare that is both high-quality and humanistic in its approach.

The practical implications of the vastly different Mean Rank scores (144.08 vs 52.53) highlight an urgent need for systemic transformation across all primary healthcare facilities in Gowa Regency. First, the significant gap suggests that maintaining the conventional, non integrated service model may lead to a continuous decline in public trust and facility utilization, as patients clearly perceive a superior quality of care in the integrated system. Therefore, a standardized scale up of the ILP model is not merely a policy recommendation but a practical necessity to ensure service equality and eliminate the quality disparity between urban and rural health centers. Furthermore, the high satisfaction in the ILP group implies that the lifecycle-based cluster approach facilitates better patient retention. Practically, this means patients are more likely

to comply with long term monitoring for non communicable diseases, such as hypertension and diabetes, which are currently the primary burdens in the regions SPM. For healthcare managers, these findings indicate that investing in staff training for specific lifecycle clusters and reorganizing physical facility layouts to match the integrated workflow will yield a significant return in terms of public health outcomes and institutional performance ratings. In essence, the transition to ILP serves as a practical vehicle to transform Puskesmas from a mere treatment center into a proactive, patient-centered health hub that effectively addresses the community's evolving needs.

CONCLUSION

This study has successfully demonstrated that a significant difference exists in patient satisfaction levels between Puskesmas implementing the Primary Care Integration (ILP) system and Non-ILP Puskesmas in Gowa Regency. These findings confirm that the transformation from a disease-based model to an integrated life cycle approach has empirically enhanced patient perceptions across all service quality dimensions, including reliability, responsiveness, assurance, empathy, and tangibles. The main scientific contribution of this study lies in its empirical validation of the life-cycle-based cluster model as a superior framework for primary care delivery, providing a robust evidence-based benchmark for health services science that correlates systemic structural reorganization with multidimensional service quality.

The policy implications of these findings for the broader development of primary health care services are significant. First, the documented success of the ILP model provides a strong mandate for health authorities to accelerate the standardization of cluster-based services nationwide to eliminate inter regional quality disparities. Second, future policies should integrate patient centered experience metrics as a formal part of the national Minimum Service Standards (SPM) evaluation framework, moving beyond mere administrative coverage targets. Furthermore, the nearly threefold difference in satisfaction ranks serves as a critical evidence-based justification for the national scale up of the ILP initiative as an effective intervention to address service fragmentation.

Regarding directions for future research to deepen the analysis of patient satisfaction, several paths are recommended. Future studies should move toward longitudinal designs to assess the sustainability of satisfaction levels over time and investigate the correlation between high satisfaction scores and actual clinical outcomes, such as treatment adherence and chronic disease control. Additionally, the adoption of mixed-methods approaches is suggested to explore the operational barriers faced by healthcare workers, while comparative studies across diverse geographic settings will further test the scalability and adaptability of this integrated model.

ACKNOWLEDGEMENTS

The authors wish to express their gratitude to all parties involved in this study, including the outpatient patients at the participating Puskesmas who graciously served as research respondents.

References

Andrianto, C., Hilmiana, H., & Nidar, S. R. (2025). Tinjauan Literatur: Peran Kualitas Pelayanan dan Kualitas Produk/Jasa Dalam Meningkatkan Loyalitas Peserta BPJS Kesehatan di Fasilitas Kesehatan. *The World of Public Administration Journal*. https://doi.org/https://doi.org/10.37950/wpaj.v7i2.2540

Anisah, I., Nasution, Z., & Yuniati, Y. (2022). Faktor-Faktor Kualitas Pelayanan Kesehatan yang Mempengaruhi Kepuasan Pasien Rawat Jalan di Puskesmas Binjai Kota. *Journal of Healthcare Technology and Medicine*, *8*(2), 1252–1262. https://doi.org/tps://doi.org/10.33143/jhtm.v8i2.2393

Anjara, S. G., Bonetto, C., Ganguli, P., Setiyawati, D., Mahendradhata, Y., Yoga, B. H., Trisnantoro, L., Brayne, C., & Van Bortel, T. (2019). Can general practitioners manage mental disorders in primary care? A partially randomised, pragmatic, cluster trial. *PLoS One*, *14*(11), e0224724.

Astuti, D. (2026). *Panduan Hidup Sehat untuk Wanita*. Victory Pustaka Media.

Fatimah, A. (2023). *Pemetaan Pola Sebaran Fasilitas Kesehatan Tingkat Ii Menggunakan Metode Nearest Neighbour Analysis Di Kota Bandar Lampung Tahun 2022*.

Hanaruddin, D. Y. (2021). Desain Penelitian Kesehatan. In P.P.RYohannes (Ed.), *Metodologi Penelitian Kesehatan* (pp. 66–87). Yayasan Penerbit Muhammad Zaini.

Hidayat, A. (2017). *Cara Hitung Rumus Slovin Besar Sampel*. Statistikian. https://www.statistikian.com/2017/12/hitung-rumus-slovin-sampel.html

Husain, H., Badwi, A., & Oruh, S. (2025). Analisis Penerapan Integrasi Pelayanan Kesehatan Primer (ILP) di Puskesmas Topore Kabupaten Mamuju Provinsi Sulawesi Barat. *Jurnal Pemberdayaan Dan Pejuang Kesehatan*, *1*(1), 16–35.

Kemenkes RI. (2023). Keputusan Menteri Kesehatan Republik Indonesia Nomor HK.01.07/MENKES/157/2018 Petunjuk Teknis Integrasi Pelayanan Kesehatan Primer. *Pedoman Pelaksanaan Promosi Kesehatan Di Puskesmas*.

Khairani, M., Salviana, D., & Bakar, A. (2021). Kepuasan pasien ditinjau dari komunikasi perawat-pasien. *Jurnal Penelitian Psikologi*, *12*(1), 9–17. https://doi.org/https://doi.org/10.29080/jpp.v12i1.520

Mait, T. O., Rosyidah, R., & Sulistyawati, S. (2025). Evaluasi Kesiapan Promkes dalam Impelementasi Program Integrasi Layanan Primer (ILP) di Puskesmas. *Jurnal Penelitian Inovatif*, *5*(1), 133–140. https://doi.org/https://doi.org/10.54082/jupin.1029

Maryuni, M. (2024). *Wanita dan Kesehatan Keluarga*. Get Press Indonesia.

Meriam, S., Sangkala, S., & Nara, N. (2025). Partisipasi Masyarakat dalam Evaluasi Pelayanan Kesehatan Publik: Studi Interaksi Dua Arah di Kabupaten Jeneponto. *PAMARENDA: Public Administration and Government Journal*, *5*(2), 473–489. https://doi.org/https://doi.org/10.52423/pamarenda.v5i2.221

Permana, I., Suryaman, S., & Febrian, F. (2023). Pengaruh Aspek Tangibles, Reliability, Responsiveness, Assurance, dan Empathy Terhadap Kepuasan Pasien Pada Pelayanan Rawat Inap di Rumah Sakit (Studi Pada Rsud Waled Kabupaten Cirebon). *Jurnal Greenation Ilmu Akuntansi*, *1*(3), 128–136. https://doi.org/https://doi.org/10.38035/jgia.v1i3.99

SDGs. (2023). *Goal 3: Ensure healthy lives and promote well-being for all at all ages*. https://www.un.org/sustainabledevelopment/health/

Sembiring, A., Simarmata, A., Manihuruk, E., Siregar, G., Naibaho, L., Sitepu, T., & Sitohang, B. S. (2025). Pengaruh Pendidikan Kewarganegaraan Terhadap Kesadaran Mahasiswa Kesehatan Tentang Hak Pasien. *Jurnal Penelitian Ilmu Kesehatan*, 27–38.

Sepriano, S., Suharyanto, S., & Judijanto, L. (2025). *Service Quality di Layanan Kesehatan*. PT. Sonpedia Publishing Indonesia.

Sianturi, L., Ahmad Hafizullah Ritonga, & Rahmad Gurusinga. (2025). Factors of Health Service Quality Dimensions Related to Patient Satisfaction. *JURNAL KESMAS DAN GIZI (JKG)*, *8*(1). https://doi.org/10.35451/zrwy6m39

Sugondo, F. R., Faustina, P., & Bernarto, I. (2021). Pengaruh efisiensi waktu tunggu, biaya pelayanan, kebersihan, serta kenyamanan ruangan terhadap kepuasan pasien (Studi pada pelayanan instalasi rawat jalan Rumah Sakit Medika Lestari). *Jurnal Manajemen Kesehatan Indonesia*, *9*(3), 205–214. https://doi.org/https://doi.org/10.14710/jmki.9.3.2021.205-214

Tripathi, S. N., & Siddiqui, M. H. (2020). Assessing the quality of healthcare services: A SERVQUAL approach. *International Journal of Healthcare Management*.

Ulfah, R. (2025). Perencanaan Integrasi Layanan Primer (ILP) di Lingkungan Dinas Kesehatan Kota Tasikmalaya. *Jurnal Ilmiah Koordinasi*, *4*(01), 313–326.

Upadhyai, R., Jain, A. K., Roy, H., & Pant, V. (2019). A review of healthcare service quality dimensions and their measurement. *Journal of Health Management*, *21*(1), 102–127.

Wida, W., & Ida, I. J. F. (2023). Efektivitas Dan Efisiensi Pelayanan Kesehatan Pada Puskesmas DTP Gununghalu. *EKONOMIKA45: Jurnal Ilmiah Manajemen, Ekonomi Bisnis, Kewirausahaan*, *11*(1), 195–209. https://doi.org/https://doi.org/10.30640/ekonomika45.v11i1.1152

Wisni, A., Joko Murdiyanto, Ahmad Faesol, Sekar Sari Arum Palupi, Hasya Naila Afina, Syahdan Narendra, & Nydia Putri Ramadhanti. (2025). Skrining kesehatan dasar dan edukasi berbasis komunitas. *BEMAS: Jurnal Bermasyarakat*, *6*(2). https://doi.org/10.37373/bemas.v6i2.1826

Wu, Q., Amporfro, D. A., Boah, M., Yingqi, S., Cheteu Wabo, T. M., Zhao, M., & Ngo Nkondjock, V. R. (2021). Patients satisfaction with healthcare delivery in Ghana. *BMC Health Services Research*, *21*(1). https://doi.org/10.1186/s12913-021-06717-5

Zamzami, I., & Jais, S. (2026). Memetakan dukungan dan hambatan peran kader dalam integrasi layanan primer di puskesmas: scoping review. *Riwayat: Educational Journal of History and Humanities*, *9*(1), 278–295. https://doi.org/https://doi.org/10.24815/riwayat.v9i1.140