THESIS

THE ANALYSIS OF HEALTH QUALITY PRESENTED TO IMMIGRANTS AT WAHIDDIN SUDIROHUSODO HOSPITAL IN MAKASSAR

By;

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Menyatakan dengan ini bahwa Tesis dengan **The Analysis of Health Quality Presented to Immigrants at Wahiddin Sudirohusodo Hospital in Makassar.**

Adalah karya saya sendiri dan tidak melanggar hak cipta pihak lain. Apabila di kemudian hari Tesis karya saya ini terbukti bahwa sebagian atau keseluruhannya adalah hasil karya orang lain yang saya pergunakan dengan cara melanggar hak cipta pihak lain, maka saya bersedia menerima sanksi

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Abdallah Hamad Elmagboul

ABSTRACT

ABDALLAH HAMAD ELMAGBOUL. **The Analysis of Health Quality Presented to Immigrants at Wahiddin Sudirohusodo Hospital in Makassar.** (Supervised by: H. Osman Lewongka, Hj. Dian A. S Parwansa).

Many refugees and migrants do not have access to health care services, barriers to accessing health care services. Language and cultural differences, high costs, discrimination, administrative barriers, and disability All of these conditions make care very difficult. This study aims to determine the relationship between quality of health services and satisfaction of immigrants in RSUP. Dr. Wahidin Sudirohusodo Makassar. The purpose of this study was to determine the effect of health service quality on immigrant satisfaction at Wahiddin Sudirohusodo Hospital in Makassar.

This research utilized analytic schemes with a quantitative approach. The sample selection method was purposive accidental. The data collection technique utilizes questionnaire and observation. The data analysis technique employed was statistical Package for the Social Sciences (SPSS). The results showed that the dimensions of quality of health service (Reliability, Responsiveness, Assurance, Empathy and Tangible) had a significant effect on immigrants' satisfaction.

Keywords: Immigrants, patients’ satisfaction, quality of healthcare.

Contents

CHAPTER I

INTRODUCTION

1.1 Background

Migration or movement of people from their home nations to other countries is not a new phenomena, Over the centuries, long before countries were formed, humans had traveled to move looking for a better life by pursuing better fortunes in other countries, that had resulted in positive aspects and negative aspects of both developed and developing countries. Due to increased globalisation, migration is on the rise. According to the United Nation, international immigrants reached 244 million in 2015. Immigrants leave their countries for various reasons; some migrate to secure employment, escape war and disasters, reunite with their families or get a better education (UN, 2015).

Movements of migrations in various countries, have an impact on all aspects of life, especially in the field of health services. In the implementation of health services for humans, there are many obstacles or problems that often occur, as well as for immigrants who need health services. The basic health needs of immigrants are not always handled adequately. There is also a close relationship between population movements and disease outbreaks. All these problems make the health of immigrants an important health issue. (International Organization of Migration, 2018)

The right to health care is a universal, fundmental social right inscribed in various international treaties and texts. These texts include binding international State commitments under the United Nations, The Universal

Declaration of Human Rights states that “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including health care and necessary social services (United Nations,1948)

Many refugees and migrants do not have access to health-care services, including health promotion, mental health services, disease prevention, treatment and care, Obstacles to access to health care services vary from country to country and may include language and cultural differences, high costs, discrimination, administrative obstacles, inability to associate with local health financing systems, unfavorable living conditions, occupation or blockade of areas, Information on health benefits is not available. All these conditions have made it difficult to provide care. (WHO, 2017)

In addition, there is another difficulty in ensuring that migrants have access to health services on an equal footing with others. This may require different approaches based on the organization and financing of each health system. Consideration should be given to creating a sustainable guarantee between the country of origin or country of return, the country of transit and the country of destination, particularly for temporary and illegal migrants, whose legal status does not allow access to health services. Health systems are also particularly difficult in countries with rapid influxes of migrants over short periods, Though the challenges refugees face in accessing health care vary in complexity. There are many barriers that refugee2s must overcome in order to receive effective healthcare. (UNHCR, 2017)

Access of immigrants to health services in the country of reception constitutes a parameter that, on one hand, ensures the basic human rights and,

on the other hand, contributes to the immigrants' social inclusion. equal access of immigrants to primary healthcare, in relation to the native population, although immigrants are more likely to report dissatisfaction, in terms of healthcare needs being met and termination of therapy. (Schutt, R. K., & Mejía, C. 2017).

However, immigrants who reside in Indonesia, also face significant obstacles when trying to access the health care system, such as long waiting time in hospitals, deficient communication with health professionals, high cost (out-of-pocket payments) and complexity of the health system. Additionally, foreigners are faced with financial insecurity at a greater degree than the native population, for the reason that their income is generally lower, while significant barriers are documented in the provision of information, concerning the Medicare and the immigrants' and refugees' ignorance in relation to their rights. (European Commission, 2006)

Besides the serious issue of the access to health-care services, another crucial matter, that constitutes a widespread requirement of contemporary developed societies, is the quality for the provided health services. Measurement of the patients' degree of satisfaction constitutes one of the most important parameters for documenting the quality of the health services and induces many benefits to the health units and, as an extension, to a wider social context. When satisfaction varies in relation to ethnicity and immigrant status, it can also reinforce health disparities, Immigrants deserve special attention as they constitute a very sensitive social group, facing an increasing risk of social exclusion. The access of immigrants to health services is one of the most

important factors that contribute to the patients' satisfaction and the amount of the health services provided with high quality (Vozikis, A., & Siganou, M. 2015).

Donabedian defined patient satisfaction as the outcome index of provided health services. He claims that patient satisfaction reflects her opinion on the quality of healthcare services and represents specific qualitative features that are mainly related to the patient's expectations and values. Patient satisfaction, according to Yucelt, constitutes the confirmation, or not, of pursuit concerning the quality and effectiveness of the services provided. While what a patient requires from a hospital is therapy, the inability to evaluate clinical care leads to a variety of other factors which affect one's judgment, such as the way health services deal with complaints, the health professionals' behavior, the immediacy of healthcare provision, the convenience of the services and, in general, the overall image of the hospital (Vozikis, A., & Siganou, M. 2015).

To achieve the highest degree of public health through health efforts as proclaimed the need for good and quality health services by health providers, therefore high performance is demanded from the health providers themselves. Hospitals that serve immigrants always try to serve well in all treatment needs including curative, preventive, promote and rehabilitation services in the hope that patients who receive health services feel satisfied.

Understanding immigrant health backgrounds in addition to recognizing the barriers and challenges affecting their health is an important factor in providing high-quality health services that lead to improving the health and satisfaction of immigrants.

1.2 Problem Statement

Based on the background description, the problem is what the factors can affect immigrant's satisfaction and quality of health services at RSUP. Dr. Wahidin Sudirohusodo Makassar?

Based on the main problem above, the following research questions are:

1. Do the tangible, responsiveness, empathy, assurance, and reliability have a positive and significant effect on immigrants Satisfaction?
2. Do the tangible, responsiveness, empathy, assurance, and reliability have a positive and significant effect on quality of health services?
3. Does the quality of health services have a positive and significant effect on immigrants Satisfaction?

1.3 Research Objectives

In general, the purpose of this study is to analyze the factors that influence the quality of health services for immigrants in RSUP. Dr. Wahidin Sudirohusodo Makassar

1. To analyze the effect of tangible, responsiveness, empathy, assurance, and reliability on immigrants Satisfaction.
2. To analyze the effect of tangible, responsiveness, empathy, assurance, and reliability on quality of health services.
3. To analyze the effect of quality of health services on immigrants Satisfaction.

1.4 Research Benefits

The results of this study are expected to provide the following benefits:

1. The research results are expected to provide information and input for health workers in providing the quality of health services, especially for immigrants.
2. Provide basic information and data for future researchers, especially those related to this research.
3. As information material as well as input for hospital so that it can improve health services for immigrants.

CHAPTER I I

LITERATURE REVIEW

2.1 Theoretical basis

2.1.1 The Concepts of Migration

How can researchers attempt to explain differences in health and access to healthcare between immigrants and non-immigrants? I argue that, although migrants are constituted by heterogeneous groups, it is possible to define some common denominators using the concepts of migration and ethnicity. These concepts represent equally important but different approaches to exploring 'the effect on health' of being a migrant. Unfortunately, they are often treated separately and rarely described as interconnected processes.

1. Migration

The word migration derives from the Latin word 'migrare', which means to move. Migration is intrinsically linked to the development of both sending and receiving countries. Thus, the nature and size of migration is determined by a complex interplay between push factors such as war, poverty, human rights abuses and hunger; and pull factors such as job possibilities and human rights protection. Migration may simply be defined as: "The movement of a person or group of persons from one geographical unit to another across an administrative or political border, with the intention of settling indefinitely or temporarily in a place other than their place of origin" (International Organization of Migration 2008).

This definition does not, however take into account that migration implies a sociodynamic process. Syed & Vangen account for this in their definition of migration as: "…a process of social change, whereby an individual moves from one cultural setting to another for the purpose of settling down in the new environment either permanently or for a prolonged period". This definition refers to a process that encompasses environmental, biological, economic, social and

cultural aspects related to up-rooting, travelling and restabilising. Although, there are no exact definitions of when the migration process stops, migration is mostly applied as an analytical framework in the context of first-generation migrants. Migration history varies according to receiving countries. In some European states ex-colonial migration has been known for decades whereas other countries like Denmark are relatively new migrant countries. I argue that in countries with a continuous influx of new migrants, migration is equally important as ethnicity to take into consideration as determinant of migrants' health (Attanapola, C. T. 2013).

The interaction between migration and health is a multifaceted and dynamic one, which encompasses migrants' genetic, socioeconomic and cultural characteristics as well as their previous health history, conditions of resettlement and access to healthcare. Factors associated with migration may have both positive andnegative effects on health. It has been shown that migrants are healthier upon arrival in relation to chronic disease compared to non-migrants ('the healthy migrant effect'), although this effect may diminish over time. Conditions related to the migration process may, however, also increase vulnerability to ill health. This link between migration and health especially arises because the process of migration is associated with a number of risk factors for ill health. (Carballo, M., & Mboup, M. 2005).

These risk factors may be divided according to the different stages of the migration process: Pre-migration risk factors include events in the country of origin such as: conflicts, torture, being detained, living in refugee camps, violence and poverty. Also, access to healthcare services may have been difficult due to conflict or poverty. Migrants may also have experienced risk factors for ill-health during the journey itself including: insecurity and lack of access to food, water and medical assistance. In particular, human trafficking may imply serious health hazards. Post-migration risk factors are associated with living conditions in the receiving country, and include diverse risk factors such as: legal restrictions on access to healthcare, long lasting asylum procedures resulting in prolonged existential uncertainty, language difficulties, social isolation, discrimination and unemployment. Additionally, migrants are

‘new’ to the healthcare system in receiving countries and may receive limited introduction to this topic (IOM, 2004)

2. About Immigrant

According to the International Organization for Migration (IOM), migration is defined as the movement of a person or a group of persons, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, economic migrants, and persons moving for other purposes, including family reunification. People on the move are often denied basic human rights, including access to social and health services. Those rights are universal and as such, should be respected and granted regardless of the individual’s legal status (IOM, 2017)

IOM Definition of “Migrant” An umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. The term includes a number of well-defined legal categories of people, such as migrant workers; persons whose particular types of movements are legally-defined, such as smuggled migrants; as well as those whose status or means of movement are not specifically defined under international law, such as international students. (IO Sironi, A., Bauloz, C., & Emmanuel, M. 2019).

3. Barriers to health care for immigrants

the barriers in relation to accessing healthcare services by immigrants in Indonesia. the immigrants had illegal residence in the host country, which entitled them to not equal access to healthcare services as the native population, various factors made access to services a challenge. These are communication and language, culture, healthcare providers' attitudes, knowledge about health system structure, stigmatization and fear and level of education. Based on the studies reviewed, the barriers experienced by immigrants when accessing healthcare services seemed to be interrelated; an impediment in a healthcare sector affected other sectors.

a. Communication and language barriers

Communication problems in a healthcare setting were found to contribute to misunderstanding and create obstacles to access to healthcare services and health inequalities, communication problems a source of barrier in the doctor-patient relationship. Communication is not exclusively verbal but also non-verbal (body language, clothing, food facial expression, gestures, eye contact and tone of voice) and primarily influenced by different cultural backgrounds, which may hamper access to adequate health information; and access to care and services. (Håkonsen, H., Lees, K., & Toverud, E. L. 2014).

Lack of language skills as a significant barrier to counselling of migrant patients and access to information. According to Goth and Berg, doctor-patient communications involving immigrants was significantly hampered by the lack of common skills in any language and health literacy. Language problems were shown to impede understanding of the health system and confidence in the

general practitioner, leading to frequent utilization of emergency care. Language barrier made communication between care providers and migrant patients, especially those who are more in need of healthcare services problematic. (Czapka, E. A., & Sagbakken, M. 2016).

According to Goth and Berg, limited language abilities meant that some migrant patients need more time to describe their problems. Language barriers increase with the use of telephone interpreters because it makes it more challenging for immigrant patients to explain their symptoms and health status, which often result in the frequent use of emergency services. Communication problems involving the use of an interpreter require additional time and resources. Goth and Berg, reported that the utilization of language interpreters from the same community as the immigrant patient might also create insecurities regarding the professional conduct of the translator for maintaining confidentiality. (Småland Goth, U. G., & Berg, J. E. 2011).

Migrants in Indonesia prefer to use the English when they go to get health services due to insurmountable language barriers, resulting in a misunderstanding of the doctor-patient relationship and their refusal to visit doctors (57). Furthermore, the use of not professional interpreters may not guarantee an excellent communication between migrants and healthcare providers but may lead to misuse of translator and communication barrier if the interpreter does not speak, he right dialect. Misinterpretation of the needs of migrants or the information from the doctor to the migrant patient may lead to health inequalities and lack of access to care. (Lindkvist, P., Johansson, E., & Hylander, I. 2015).

b. Cultural barriers and sensitivity

The patriarchal culture and religious beliefs often lead to cultural collisions between healthcare professionals and migrants. The dissimilarities in cultural beliefs, expectation and behaviors may result in miscommunication and misunderstanding. Cultural diversities, religious beliefs and norms, and language barriers affect access to available information, the type and quality of information given to immigrants, their understanding of the information received and their decisions to accept and adhere to some types of treatment and medications. (Akhavan, S. 2012).

c. Healthcare providers' attitude or response

Healthcare providers' attitudes and behavior are influenced greatly by professional norms, such as, attitudes, values, meaning, and preferences, these are created by professional training, and further shaped by life experiences, and interaction between healthcare professionals and their social environment. Health services for immigrants are dynamic and impacted by care providers' attitudes and immigrants' health need, and influenced by underlying healthcare system.(Suphanchaimat, R., 2015).

According to Harpelund et al, language barriers can diminish healthcare providers' perception of migrant's health problems. A poor provision of competent linguistic services may limit immigrants' ability to communicate comprehensively with healthcare providers and understand the information they are provided. (Harpelund, L., 2012).

According to Salinero-Fort et al. immigrants lose the health advantage they had upon arrival, and their health deteriorates with the length of stay in the host countries, and due to low-education, poverty and discrimination. Additionally, access barriers heighten the health conditions of immigrants and hinder them from integration, and lack of integration leads to marginalization, and marginalization exacerbates the process of health status, and health conditions heighten marginalization. Hence, immigrants' access needs should be an area of concern to public health professionals because barriers to accessing healthcare services by immigrants impede integration. In contrast, immigrants in good health who have successfully integrated into the new sociocultural context, are more receptive to employment and education, and resultantly are more able to approach the challenges they encounter in the host societies. Furthermore, integration is essential for adequate delivery of healthcare services. (Norredam, M. 2011).

d. Level of education and barriers

Level of education was believed to impede female immigrants' utilization of healthcare services. Immigrants from the Middle East were thought to have a reduce understanding or lack of access to available information due to Low education among them. However, pharmacists who sometimes suspect immigrant patients or clients to be illiterate, occasionally issue written information or point them to the written instruction on the package with no possibility of knowing if the information is understood. This may lead to misuse of the drugs, which may further complicate the patients' health. Access to an accurate information may guide the patients on why they should comply with their treatments, and how and when to take their drugs. Language problems

and unfamiliarity with the health system may create difficulties navigating the system, leading to dissatisfaction and resulting in lack of compliance with treatment (Akhavan, S. 2012).

e. Residential location

Immigrants in new destinations probably have a different set of social networks than those in traditional destinations. Recent immigrants in new destinations are likely to know relatively fewer immigrants who are long-term residents to whom they can turn for assistance and knowledge about the health care system. This may cause newer immigrants to delay care until the problem becomes unbearable, or they and their providers might encounter frustration when they do attempt to seek care.

2.1.2 Health Services for immigrants

1. The health rights

The right to the highest attainable standard of health was first reflected in the World Health Organization Constitution of 1946 (WHO, 1964) and then reiterated in the 1978 Alma Ata Declaration and in the World Health Declaration of 1998 (WHO 1998). Numerous international human rights documents also recognize the right to health. Thus, the Universal Declaration of Human Rights (UDHR) states: “Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of her/his family, including food, clothing, housing and medical care…” (DECLARATION, O. 1948). Also, the International Covenant on Economic, Social and Cultural Rights (ICESCR) affirms: “…the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. Declarations like the UDHR are non-binding, whereas

treaties like the ICESCR are binding on governments that ratify them. (COVENANT, P. 1966).

The notion of the right to health is grounded in the field of health and human rights. In particular, it has been promoted by Harvard professor Jonathan Mann. Together with colleagues he advocated that human rights provide a framework to promote health and prevent disease (Grodin, M., 2013). and that the UDHR should be used as a powerful public health document in line with the Hippocratic Oath of clinical medicine (Annas, G. J., & Grodin, M. A. (1996). But what are the linkages between health and human rights? Three main areas are agreed on (WHO, 2002):

a. Public health policies and programs can promote or violate human rights in the ways they are designed or implemented.
b. Violations of human rights can have serious consequences for physical and mental health.
c. Vulnerability and the impact of ill health can be reduced by strengthening human rights.

The right to health may sound strange. Superficially, it seems to presume the absurd assumption that governments or international organizations must guarantee persons good health. In this sense critics have argued that the phrase a right to health is conceptually misleading, and that "…a more correct phraseology would be a right to health protection including two components, a right to healthcare and a right to healthy conditions" (Leary, V. A. 1994). This is also in line with WHO's 2002 interpretation of: "… the right to health as an

inclusive right extending not only to timely and appropriate healthcare but also to the underlying determinants".

Thus, a right to healthcare can be seen as part of the right to health. Mary Robinson, the former United Nations High Commissioner of Human Rights, articulated this association: "The right to health does not mean the right to be healthy…But it does require governments and public authorities to put in place policies and action plans which will lead to available and accessible healthcare for all in the shortest possible time" (WHO, 2002).

The field of health and human rights is still in its infancy within public health. Not least as a framework for the study of migrants' health and access to healthcare. Overall, human rights may benefit work in the area of public health by providing a framework for studying health developments among (vulnerable) populations, especially in relation to the human rights implications of health policies, programmes and legislations. To date, this approach has especially been developed in relation to the poor and sick in developing countries (Farmer, P. 1999).

However, I argue that this framework is also relevant when considering vulnerable populations in developed countries. Indeed, some of the most vulnerable groups in our societies are refugees and other migrant groups. Their vulnerability is related to several things including risk factors related to: the process of migration, ethnicity, communication, low socioeconomic status, marginalization and the fact that their legal rights to healthcare may be infringed. I argue that a human-rights-based perspective represent a relevant but somewhat unexplored approach to migrants' access to healthcare.

2. Equity in healthcare

The concept of health and human rights is closely linked to a more familiar public health concept namely equity in health, which consequently deserves mentioning in this context. According to Whitehead (Whitehead, M. (2000). “equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged…”. Braveman & Gruskin have elaborated on his definition to make it more operational for policymakers and researchers: “Equity in health can be defined as the absence of systematic disparities in health between groups with different levels of underlying social advantage/disadvantage”. (Braveman, P., & Gruskin, S. 2003)

Equity concerns fairness whereas equality concerns differences in a mathematically sense. Equitable healthcare requires that resource allocation and access to healthcare are determined by health need. Thus, equity in access to healthcare is seen when need determines the allocation of resources irrespective of irrelevant factors such as ethnicity or migration status. Horizontal equity implies equal treatment when equal needs and vertical equity implies different treatment for different needs. Tailoring interventions to migrants’ needs therefore often concerns vertical equity. **(**Oliver, A., & Mossialos, E. 2004).

3. The concept of access to healthcare

Overall, the aim of facilitating access to healthcare is to help people to appropriate healthcare services to optimise health. The idea being that improved access to healthcare can reduce disparities in health – hence the

linkage to health and human rights and equity in health. Despite a vast literature on access, there is currently no generally accepted definition here of On a general level access has been described as the ‘fit’ between patients and the healthcare system (Oliver, A., & Mossialos, E. (2004).

More concretely, Rogers et al. defined optimal access as “providing the right service at the right time in the right place”. Gulliford et al. describe access as a multidimensional concept which firstly depends on the availability of services. However, facilities may be available without people using them. Consequently the next step is to ensure that people use services when needed. (Rogers, A., 1999).

utilisation may be influenced by need as well as acceptability, affordability and physical accessibility of services. Thus, the probability of utilising services again depends on the balance between individual’s perception of their needs, attitudes, beliefs and previous experiences. (Gulliford, M., 2002).

4. Factors Affecting the access to Health-care Services

According to World Health Organization that behavioral factors that influence the use of health services are:

a. Thoughts and Feeling

   In the form of knowledge, perceptions, attitudes, beliefs and assessments of a person towards health objects.

b. Personal Reference

Someone is more influenced by someone who is considered important or has a big influence on the encouragement of the use of health services.

c. Resources

Includes facilities, money, time, energy, and so on. Resources also affect the behavior of a person or community group in utilizing health services. These effects can be positive and negative.

d. Culture

Forms the norms that exist in society in relation to the concept of healthy sick.

2.1.3 Quality of Health Services

1. Definition of quality

According to Goetsch and Davis (1994) Quality is a dynamic condition associated with service products, people, processes and the environment that meets or exceeds the expectations of those who want it. According to Tenner and De Toro (1992) that values the most quality easy to understand from a single product or service is faster, cheaper and better.

According to Parasuraman (1990), perceived service quality by customers (perceived service quality) is defined as how big is the gap between customer perceptions or the reality of the service received compared to customer expectations for the service received.

Deming (1980) states that quality can be seen from:

1. Aspects of Quality is a characteristic or attribute of a product or service.

2. Aspects of Customer Perception, Quality is a subjective assessment of customers. Customer perception can change due to the influence of various things such as advertising, the reputation of the product or service produced, and so on.
3. The aspects of customer needs and desires, quality is what is on will and is needed by the customer.

2. Quality of health services

Service is an effort to help prepare (take care) what is needed by others, In general, the quality of health services is the degree of perfection of health services in accordance with service standards by using resources that are available in hospitals or health centers in a reasonable, efficient and effective manner provided safely and satisfying norms, ethics, law, and social culture ith pay attention to the limitations and capabilities of the government and society (MOH. RI: 2006)

The quality of health services is an appropriate and appropriate performance (which is related to standards) of an intervention that is known to be safe, which can give results to the community concerned and that has the ability to have an impact on death, illness, disability and malnutrition (Milton I Roemer and C. Montoya, WHO, 1988).

The quality of health services is the degree to which the needs of the community or individuals for health care are in accordance with good professional standards with the use of resources that are reasonable, efficient, effective in the limited capacity of government and society, and are held safely

and satisfying customers in accordance with norms and good ethics (Azrul Azwar, 1999)

From what has been stated above, it can be concluded that quality health service is the suitability of health services with standards profession by making good use of available resources, so that all customer needs and goals to achieve health degrees the optimal.

The quality of health services at the Public health center and at the hospital is the final product of complex interactions and relationships between various components or aspects of service. Donabedian (1980) states that the service component can consist of:

a. Input

Inputs referred to here are physical facilities, equipment and equipment, organization and management, finance, as well as human resources and other resources in health centers and hospitals. Some important aspects that need attention in this regard are honesty, effectiveness and efficiency, as well as the quantity and quality of existing input.

b. Process

Process is all activities or activities of all employees and professionals in interaction with customers, both customers internal (fellow officers or employees) or external customers (patients, suppliers of goods, people who come to the health center or hospital for a specific purpose. Whether or not the process carried out at the health center or at the hospital can be measured from:

a. Relevant or not the process received by the customer.
b. Effective or not the process carried out.
c. The quality of the process.

Process variables are a direct approach to the quality of health services. The more obedient officers (professions) are to service standards, the more quality the health services they provide.

c. Output

the expected result that can be a change that happens to customers, both physically, physiologically and social, and including customer satisfaction.

3. Dimensions of Quality

According to Parasuraman, Zeithaml, and Berry (1990) there are five dimensions to measure the quality of service known as ServQual. The five dimensions include:

a. Reliability

Reliability is the ability to provide services immediately, accurately (accurately), and satisfying. Reliability is the ability of service providers to provide services as promised, namely fast, precise and satisfying (Tjiptono, 2011).

Reliability is the seriousness of service providers in fulfilling their promises effectively, efficiently and accurately so as to satisfy consumers. Reliability is provided by the company since it first provided services (right the first time) (Irfan, 2012).

Measurement of reliability indicators, namely (Mas'ud, 2014):

a. Correction of errors is carried out quickly by the company.
b. Consistent service to customers.
c. The company strives to meet customer expectations

b. Responsiveness

Responsiveness is the level of willingness to help and facilitate customers by providing prompt service to customers (Irfan, 2012). Responsiveness is an employee's effort to help customers and provide the best possible service, which is to respond proportionally. Responsiveness is defined as the response or ability of employees to quickly assist and provide services to customers in conducting transactions (Tjiptono, 2011).

Measures of responsiveness indicators include (Mas'ud, 2014):

a. Employees provide services in a neat and orderly manner during alternate busy hours.
b. Service is quickly provided by employees.
c. Willingness of employees to help customers
d. The readiness of employees to respond to customer requests.

c. Assurance

Assurance is about the knowledge, skills and expertise of the employees involved in providing services and the ability to create trust and confidence among customers (Irfan, 2012). Guarantees in providing services include knowledge, ability, courtesy, and trustworthiness of employees and are safe (Tjiptono, 2011).

The measurement of guaranteed indicators is carried out through (Mas'ud, 2014):

a. Convenience and confidence of customers in dealing with employees created by the company
b. Customer's feeling of security when dealing with employees
c. Experienced, competent and trained employees
d. Customer questions can be answered well by employees
e. Employees are supported by the company to excel so that they can work well

d. Empathy

Is the willingness of service providers to care more about giving personal attention to customers, this dimension is a combination of aspects:

a. Communication: namely the ability to communicate to convey information to consumers or receive input from consumers.
b. Access: which is ease in taking advantage of services offered by service providers.
c. Understanding of consumers, which is a service provider know and understand the needs and desires of consumers

e. Tangible

Tangible is defined as a physical facility owned by the company in the form of buildings, equipment, laboratories and labor involved in providing services to consumers. Tangible can be interpreted as a physical appearance such as a building and its facilities, equipment and appearance of employees. (Bustami, 2011).

The indicators for measuring tangible are as follows (Mas'ud, 2014):

a. The equipment owned by the company is complete.
b. The building owned by the company is spacious.
c. Professional workforce.

The dimensions of quality expressed by Zeithml, Berry and Parasuraman affect customer expectations and the reality they receive. If the reality of the customer receiving the service exceeds his expectation, the customer will declare the service of quality and if in fact the customer receives the service that is less or equal to his expectations, then the customer will declare that the service is not quality or unsatisfactory.

2.1.4 The concepts of Patients Satisfaction

1. Definition of patient satisfaction

Patient satisfaction is a measure of the extent to which a patient is content with the health care they received from their health care provider. Patient satisfaction is one of the most important factors to determine the success of a health care facility Manzoor, (F., Wei, 2019).

The patient's opinion is becoming more important in the improvement process of a health care delivery system. Patient satisfaction is the state of pleasure or happiness that the patients experience while using a health service. Thus, patient care is the basic function of every health service provider (Li, Z., 2012). It is one of the benchmarks used to assess a hospital's efficiency and effectiveness, with the efficiency of a hospital being linked to the delivery of services and the provision of high-quality treatment (Nie, Y., 2013).

Currently, the patients' opinions are considered as a key factor in the decision of treatment and delivering health care services. Hence, the evaluation of health service delivery from the patients' perspective has received greater attention and has become a core attribute of any health system as it serves as a valuable indicator to measure the success of a service provision, especially in public sector hospitals (Mohd, A., & Chakravarty, A. 2014).

However, the quality of service delivery is considered as an essential factor in promising general patient satisfaction towards hospitals. It has been suggested that physicians and hospital staff (medical or non-medical) all ought to focus on the direction to improve as well as enhance the quality of service delivery (Jakobsson, L., & Holmberg, L. 2012).

2. Patient satisfaction importance in health care

In a major report published in 2001 ("Crossing the Quality Chasm", the Institute of Medicine (IOM) set forth six aims for a quality health care system patient safety: (a) safe; (b) equitable; (c) evidence based; (d) timely; (e) efficient; and (f) patient centered. The latter three factors directly influence patient satisfaction. (Prakash B. 2010).

Today's patient views himself as a health-care purchaser. Once this idea is recognized, it is necessary to realize that each patient has particular rights, emphasizing the need of providing high-quality health care.

higher patient satisfaction leads to benefits for the health industry in a number of ways, which have been supported by different studies:

a. Patient satisfaction leads to customer (patient) loyalty.

b. Increased staff morale with reduced staff turnover also leads to increased productivity. (Prakash B. 2010).
c. increased personal and professional satisfaction - patients who improve with our care definitely make us happier. The happier the doctor, the happier will be the patients. (Poot, F. 2004).

3. Understanding a patient

A patient's liking the doctor has a lot to do with the patient getting better. A patient's expectations of a good service depend on age, gender, nature of illness, hour of the day, his or her attitude toward the problem and the circumstances. (Brown, S. W., Nelson, A. M., Bronkesh, S. J., & Wood, S. D. 1993).

In general, patients expect their doctors to keep up the timings, behave cordially, and communicate in their language. They expect care, concern, and courtesy in addition to a good professional job. Certain tips can help a doctor or a hospital to understand the patients better:

a. Recognize that patients expect a personal relationship that shows compassion and care.
b. Recognize that the patient has got certain rights. Various regulatory authorities and hospitals have drawn a charter of rights for the patients.
c. Make sure a patient has got a good first impression of you and your set up.
d. Step into your patients′ shoes; see through their eyes and hear through their ears.

e. Minimize the patient's waiting time to the least possible.

f. Try to make your problem-solving system to be functional.

g. Always obtain feedback from your patients and correct shortcomings if any.

2.2 Previous research

Author, year, and country	Objectives	Study design	Findings
Larsson et al., 2016, Sweden	To explore health care providers' experiences of providing care to immigrant women seeking abortion care.	Qualitative/ Interview	Health care providers are reluctant to acknowledge specific needs among immigrant women; they Strive to provide contraceptive counselling to immigrant women, and they are faced with organisational barriers hindering patient-centred abortion care to immigrant women.
Rund et al., 2017, Norway	To explore reasons for attending a general emergency outpatient clinic versus a regular general practitioner (RGP).	Quantitative Crosssectional	Immigrants were more likely to contact their RGP before attending the emergency outpatient clinic compared with native Norwegians. The most frequent reason for visiting the emergency clinic was difficulty making an immediate appointment with their RGP. A common reason for not contacting an RGP among 21% of native Norwegians was lack of access; they claimed their Registered General Practitioner was in a district/municipality other were they lived, and 31% of the migrants reported a lack of affiliation with the RGP scheme
Hakonsen et al., 2014, Norway	To identify the cultural barriers encountered by Norwegian community pharmacists in providing service to non-Western immigrant patients and to outline how they are being addressed.	Qualitative/ Focus groups	The pharmacists had challenges in providing adequate service to immigrant patients. Language and cultural barriers affected what the patients got out of the available information, the kind of and how much information was provided. Although immigrant patients needed drug counselling, there were significant disparities in how much effort was exerted to provide this service. Cultural barriers were linked to differences in body language and clothing which the pharmacists thought distracted the communication.
Akhavan S. 2012, Sweden	To explore the views of midwives on the factors that contribute to health care	Qualitative/ Semistructure interview	Midwives believe inequality in health care among immigrants could be due to language barriers, miscommunication due to few meeting times, cultural differences and practices, limited patient-

	inequality among immigrants.		caregiver trust and difficulties when seeking and receiving health care.
Czapka et al., 2016, Norway	To explore barriers to and facilitators of Polish migrants' access to Norwegian health care services.	Qualitative/ Interview	Insufficient language skills, communication problems and lack of knowledge about navigating the health care system were barriers often experienced and mostly mentioned by the migrants. The organisation of the healthcare system, perceptions of doctors' skills and practices, and attitudes among health personnel were also viewed as barriers.

CHAPTER III

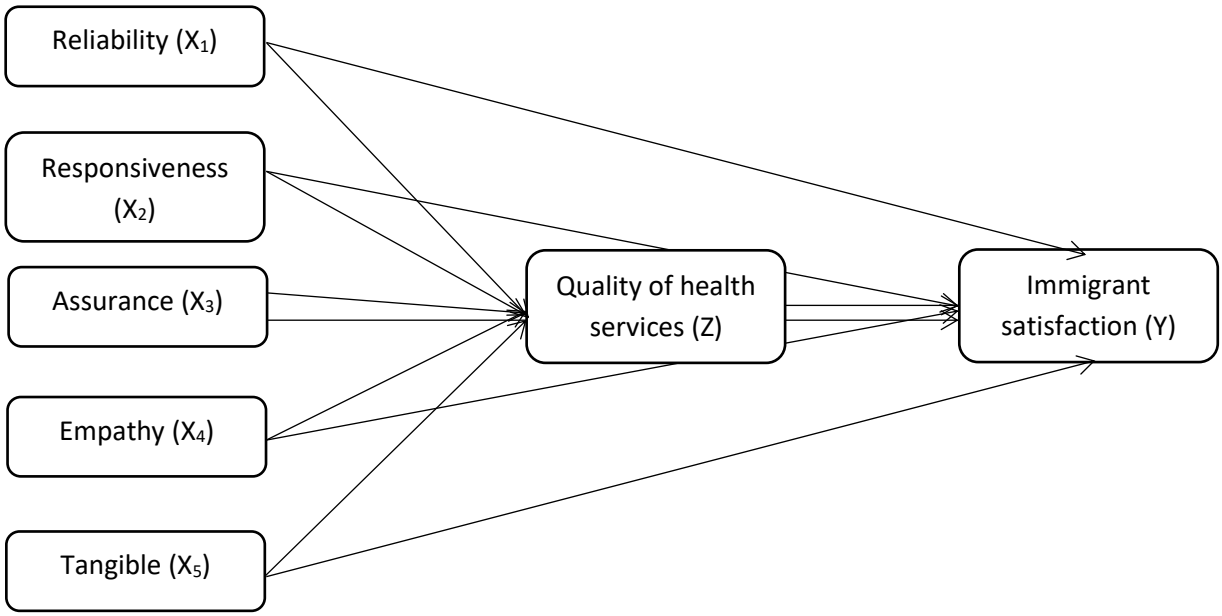
CONCEPTUAL FRAMEWORK AND HYPOTHESIS

3.1 Conceptual Framework

To find out the quality of health services, it must be known whether the service standard has run well or not. The running of service standardization can be seen from the performance process of health workers themselves in providing services to the community / patients. In accordance with the theory explained in the previous literature review, in order to complete the conceptual framework in this study, the author is guided by the theory put forward by Zeithaml, Berry and Parasuraman (2008) regarding 5 aspects of service, as follows:

1. Reliability is the ability to deliver the promised service consistently and accurately.
2. Responsiveness is a willingness to help service users and provide services in a sincere and responsive manner.
3. Assurance is the knowledge, courtesy and ability of service providers to provide trust to service users
4. Empathy is the ability to provide treatment or attention to service users personally.
5. Tangibles means the physical appearance of buildings, equipment, employees and other facilities owned by service providers.

For more details, there is a conceptual framework that forms the basis of thought in this study:



3.2 Hypothesis

The hypotheses based on the research framework above are as follows:

1. X_1, X_2, X_3, X_4, and X_5 have a positive and significant effect on Y.
2. X_1, X_2, X_3, X_4, and X_5 have a positive and significant effect on Z.
3. Z has a positive and significant effect on Y.