

Impact of health policy implementation on service quality and patient satisfaction in primary care settings: A cross-sectional study

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ABSTRACT

Introduction: Effective implementation of health policy at the primary care level remains uneven, often limiting its impact on service quality and patient satisfaction. This study aimed to examine the effect of health policy implementation on service quality and patient satisfaction in primary care settings.

Research Methodology: An analytical cross-sectional study was conducted among 145 patients attending primary healthcare facilities. Participants were selected using systematic random sampling. Health policy implementation was assessed across three domains: policy adherence, resource availability, and provider compliance. Service quality was measured using a modified SERVQUAL instrument, while patient satisfaction was assessed using a standardized Likert-scale questionnaire. Data were analyzed using descriptive statistics, bivariate analysis, and multiple linear regression. Statistical significance was set at $p < 0.05$.

Results: Health policy implementation showed a significant positive association with service quality ($\beta = 0.52$; 95% CI: 0.34–0.70; $p < 0.001$) and patient satisfaction ($\beta = 0.47$; 95% CI: 0.29–0.65; $p < 0.001$). Multivariate analysis revealed that policy adherence was the strongest predictor of service quality ($\beta = 0.31$; 95% CI: 0.18–0.44; $p < 0.001$) and patient satisfaction ($\beta = 0.29$; 95% CI: 0.16–0.42; $p < 0.001$), followed by resource availability and provider compliance, all of which remained statistically significant.

Conclusion: The findings indicate that strengthening health policy implementation, particularly adherence and resource support, is essential to improve service quality and patient satisfaction. Policy efforts should prioritize implementation fidelity, workforce capacity, and equitable resource allocation to enhance patient-centred outcomes in primary healthcare.

Keywords: health policy; patient satisfaction; primary health care; quality of health care; health services accessibility.



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INTRODUCTION

Health policy implementation at the primary care level represents a critical interface between macro-level governance and micro-level service delivery outcomes. Despite extensive policy reforms aimed at strengthening primary care systems globally, variability in service quality and patient satisfaction persists, particularly in low- and middle-income countries (LMICs) (Abdelwahed & Zehri, 2025). This inconsistency suggests that policy enactment does not uniformly translate into improved care experiences (Alboksmaty et al., 2025). Empirical reports indicate that fragmented implementation, limited institutional capacity, and contextual disparities undermine the effectiveness of policy interventions (Alshaeri et al., 2025). Consequently, understanding how policy implementation influences measurable service outcomes remains a pressing issue within health systems research (Blofield et al., 2026).

The existing literature has extensively explored the relationship between health policy and system performance; however, the findings remain inconclusive. Several studies demonstrate that well-structured policies such as universal health coverage frameworks and quality assurance regulations are associated with improved service accessibility and responsiveness (Dalton et al., 2026). Conversely, other investigations reveal that implementation gaps, including inadequate workforce training, resource constraints, and weak monitoring mechanisms, attenuate policy effectiveness (Dimitropoulos et al., 2024). Cross-national analyses further highlight that policy success is contingent not merely on design but on fidelity of implementation and local adaptability (Feely et al., 2025). Moreover, patient satisfaction, as a subjective yet essential indicator of health system performance, is influenced by both structural factors and relational dimensions, which are not always explicitly addressed in policy frameworks (Karamagi et al., 2026).

A critical limitation in current scholarship lies in the fragmented examination of service quality and patient satisfaction as separate constructs, rather than interdependent outcomes shaped by policy implementation processes (Kovacevic et al., 2026). Additionally, many prior studies adopt macro-level analyses or qualitative approaches, limiting the ability to quantify direct associations between implementation fidelity and patient-centered outcomes (Litchfield et al., 2025). There is also a paucity of context-specific evidence from primary care settings, where policy directives are operationalized and experienced by patients (Manzanera et al., 2026). Importantly, few studies employ robust cross-sectional analytical models that integrate multidimensional indicators of service quality with patient satisfaction metrics within a unified framework (Miller et al., 2026).

This study addresses these gaps by adopting an integrated analytical approach to examine the impact of health policy implementation on both service quality and patient satisfaction in primary care settings. Unlike previous research that treats these outcomes independently, this study conceptualizes them as interconnected dimensions of health system performance (Molle et al., 2025). Furthermore, the study incorporates a quantitative cross-sectional design with regression-based analysis to elucidate the strength and direction of associations between implementation variables and outcome measures (Montagna Barbosa Gouvêa et al., 2026). By situating the analysis within real-world primary care contexts, the study provides empirically grounded insights into how policy translates into practice.

The novelty of this research lies in three key aspects. First, it advances a dual-outcome framework that simultaneously evaluates service quality and patient satisfaction as co-dependent indicators of policy effectiveness. Second, it operationalizes health policy implementation through measurable constructs, including adherence, resource availability, and provider compliance, enabling a more precise assessment of implementation fidelity. Third, it contributes

context-specific evidence from primary care settings, thereby enhancing the external validity and practical relevance of findings for policymakers and healthcare administrators.

The primary objective of this study is to analyze the impact of health policy implementation on service quality and patient satisfaction in primary care settings using a cross-sectional design. Specifically, the study aims to: (1) assess the level of health policy implementation at the primary care level; (2) evaluate the quality of healthcare services delivered; (3) measure patient satisfaction levels; and (4) determine the statistical relationship between policy implementation, service quality, and patient satisfaction. Through this approach, the study seeks to generate actionable evidence to inform policy refinement and improve patient-centred care outcomes.

RESEARCH METHODOLOGY

Study Design

This study employed an analytical cross-sectional design to examine the association between health policy implementation, service quality, and patient satisfaction in primary care settings. The cross-sectional approach was selected for its suitability for assessing exposure–outcome relationships within a defined population at a single point in time, enabling efficient estimation of prevalence and statistical associations among variables.

Setting & Participants

The study was conducted in selected primary healthcare facilities (Puskesmas) in Indonesia from January to April 2025. The study population comprised adult patients (≥ 18 years) who accessed primary care services during the study period. Inclusion criteria were: (1) patients who received healthcare services at participating facilities, (2) aged 18 years or older, and (3) willing to provide informed consent. Exclusion criteria included: (1) patients with severe cognitive impairment or communication barriers, and (2) incomplete questionnaire responses. A total of 145 participants were recruited using a systematic random sampling technique based on daily patient visit lists. The sample size was determined using the single-population proportion formula, assuming a 95% confidence level ($Z = 1.96$), an expected proportion of patient satisfaction of 50% (to maximize sample size), and a margin of error of 8%. The calculated minimum sample size was 150; however, after accounting for non-response and data completeness, 145 valid responses were included in the final analysis.

Variables & Measurement

The independent variable was health policy implementation, operationalized through three domains: policy adherence, resource availability, and provider compliance. The dependent variables were service quality and patient satisfaction. Service quality was measured using a modified SERVQUAL instrument covering five dimensions: tangibility, reliability, responsiveness, assurance, and empathy. Patient satisfaction was assessed using a standardised patient satisfaction questionnaire with Likert-scale responses. All instruments were adapted from validated sources and translated into Bahasa Indonesia using forward-backwards translation. Content validity was assessed by three experts in public health and health policy. Construct validity was evaluated using exploratory factor analysis. Reliability testing demonstrated acceptable internal consistency, with Cronbach's alpha values ranging from 0.78 to 0.91. Primary data were collected directly from respondents using structured questionnaires administered after service utilization.

Data Collection

Data collection was conducted by trained enumerators who approached eligible participants after they received healthcare services. Standardized procedures were followed to ensure consistency, including briefing sessions, pilot testing, and the use of uniform data-collection tools. Quality control measures included daily supervision, random checks of completed questionnaires, and double data entry to minimize errors. Incomplete or inconsistent responses were verified or excluded based on predefined criteria.

Data Analysis

Descriptive statistics were used to summarize participant characteristics and study variables, including means, standard deviations, frequencies, and percentages. Bivariate analysis was performed using Pearson correlation and chi-square tests to assess associations between independent and dependent variables. Multivariate analysis was conducted using multiple linear regression to examine the effect of health policy implementation on service quality and patient satisfaction while controlling for potential confounders. Regression assumptions, including normality, multicollinearity, and homoscedasticity, were assessed before analysis. All statistical analyses were performed using IBM SPSS Statistics version 26.0. A p-value of less than 0.05 ($\alpha = 0.05$) was considered statistically significant.

Ethical Approval

This study received ethical approval from the Health Research Ethics Committee of Universitas Negeri Manado, North Sulawesi, Indonesia (Approval No: 045/KEPK-UNIMA/2025). Written informed consent was obtained from all participants prior to data collection. Participants were informed about the study objectives, procedures, potential risks, and their rights to withdraw at any time without consequences. Confidentiality and anonymity were strictly maintained throughout the research process.

RESULT

A total of 145 patients who met the eligibility criteria were included in the final analysis. The results are presented in three sections: participant characteristics, the distribution of service quality and patient satisfaction; and the effect of health policy implementation on service quality and patient satisfaction outcomes. Descriptive analysis was used to summarize demographic characteristics and the distribution of key study variables. In contrast, inferential analysis was used to evaluate the associations between health policy implementation and outcome variables. Table 1 presents the demographic characteristics of the respondents, including age, sex, educational level, and frequency of healthcare utilization. The majority of participants were aged 26–45 years, with a slightly higher proportion of female respondents than male respondents. Most participants had completed secondary education and reported regular visits to primary healthcare facilities.

Table 1. Characteristics of Respondents (n = 145)

Variable	Category	n	%
Age	18–25 years	32	22.1
	26–45 years	68	46.9
	>45 years	45	31.0
Sex	Male	62	42.8
	Female	83	57.2
Education	Primary	28	19.3
	Secondary	79	54.5
	Higher	38	26.2
Visit Frequency	Occasional	51	35.2

The majority of respondents were aged 26–45 years (46.9%) and predominantly female (57.2%). Most participants had secondary education (54.5%) and reported regular healthcare visits (64.8%), indicating a relatively engaged primary care population.

Table 2. Bivariate Analysis of Health Policy Implementation with Outcomes

Variable	Outcome	OR/ β	95% CI	p-value
Policy Implementation	Service Quality	0.52 (β)	0.34–0.70	<0.001
Policy Implementation	Patient Satisfaction	0.47 (β)	0.29–0.65	<0.001

Bivariate analysis showed a significant positive association between health policy implementation and both service quality and patient satisfaction ($p < 0.001$). Higher implementation scores were associated with improved perceived quality and satisfaction levels.

Table 3. Multivariate Linear Regression Analysis

Variable	Outcome	β	95% CI	p-value
Policy Adherence	Service Quality	0.31	0.18–0.44	<0.001
Resource Availability	Service Quality	0.28	0.15–0.41	<0.001
Provider Compliance	Service Quality	0.26	0.12–0.39	0.001
Policy Adherence	Patient Satisfaction	0.29	0.16–0.42	<0.001
Resource Availability	Patient Satisfaction	0.25	0.11–0.38	0.001
Provider Compliance	Patient Satisfaction	0.22	0.09–0.35	0.002

Multivariate analysis confirmed that all dimensions of health policy implementation were significant predictors of both service quality and patient satisfaction. Policy adherence demonstrated the strongest effect, followed by resource availability and provider compliance. All associations remained statistically significant after adjusting for demographic variables.

The findings provide consistent empirical evidence that the effectiveness of health policy implementation is a decisive determinant of both service quality and patient satisfaction in primary care settings. The statistically significant coefficients observed in both bivariate and multivariate models indicate that policy implementation is not merely an administrative construct but a measurable driver of patient-centred outcomes. Specifically, the magnitude of the regression coefficients demonstrates that incremental improvements in implementation domains translate into meaningful gains in perceived service quality and satisfaction.

Among the implementation components, policy adherence emerged as the most influential predictor, suggesting that fidelity to policy guidelines is more critical than policy availability alone. This implies that implementation gaps are primarily operational rather than conceptual. Resource availability also showed a substantial effect, indicating that even well-adhered policies may fail without adequate infrastructural and logistical support. Meanwhile, provider compliance, although slightly lower in effect size, remains statistically significant, reinforcing the role of frontline health workers in mediating policy impact. Importantly, the consistency of effects across both outcome variables supports the proposition that service quality and patient satisfaction are structurally interlinked and jointly shaped by implementation processes. These results highlight that strengthening implementation fidelity, rather than introducing new policies, may yield more immediate and scalable improvements in primary healthcare performance.

DISCUSSION

The present study provides robust empirical evidence that health policy implementation is a critical determinant of both service quality and patient satisfaction in primary care settings. The

observed statistically significant associations, particularly the magnitude of regression coefficients across implementation domains, indicate that policy implementation is not merely a procedural obligation but an operational mechanism that directly shapes patient-centred outcomes. Notably, policy adherence emerged as the strongest predictor, suggesting that the fidelity with which policies are executed at the facility level is more consequential than the mere existence of policy frameworks. This finding reinforces the premise within implementation science that the “implementation gap” often lies not in policy formulation but in execution processes (Nakase-Richardson et al., 2026).

Furthermore, the significant role of resource availability underscores the systemic dependence of policy effectiveness on infrastructural and logistical readiness. Even well-designed policies may fail to produce intended outcomes when resource allocation is insufficient or unevenly distributed (O'Connor et al., 2026). Provider compliance, while slightly lower in effect size, remains a statistically significant determinant, underscoring the mediating role of healthcare workers in translating policy directives into clinical practice. Collectively, these findings suggest that policy implementation should be conceptualized as a multidimensional construct encompassing structural, procedural, and behavioral components (Özden & Çelik, 2025).

Importantly, the concurrent influence of implementation variables on both service quality and patient satisfaction supports the argument that these outcomes are structurally interconnected rather than independent. Improvements in technical and functional aspects of care are likely to enhance patient perceptions and experiences simultaneously, aligning with contemporary extensions of the Donabedian framework (R. et al., 2026).

The findings of this study are consistent with a growing body of literature emphasising the central role of implementation fidelity in determining health system performance. Previous studies have demonstrated that high levels of policy adherence are associated with improved quality indicators and patient outcomes (Rudd et al., 2025). Similarly, research conducted in LMIC contexts has highlighted that gaps in implementation rather than policy absence are the primary drivers of suboptimal healthcare delivery (Shaw et al., 2026).

In line with this study, (Squires et al. (2025) reported that patient satisfaction is strongly influenced by both structural and interpersonal dimensions of care, which are often indirectly shaped by mechanisms of policy implementation. The present findings extend this evidence by demonstrating that implementation variables exert measurable effects on both outcomes simultaneously within a unified analytical model. However, some divergence from prior studies is also notable. While earlier research often treats service quality and patient satisfaction as distinct constructs, this study provides empirical support for their interdependence, suggesting that separating these outcomes may obscure the true impact of policy interventions (Sun et al., 2026). Additionally, whereas many studies rely on qualitative or macro-level analyses, the use of regression-based modelling in this study offers more precise quantification of relationships, thereby strengthening causal inference within the limitations of cross-sectional design (Suprpto, 2026).

Several limitations should be acknowledged when interpreting the findings. First, the cross-sectional design precludes definitive causal inference, as exposure and outcome variables were measured simultaneously. Although significant associations were identified, the temporal direction of relationships cannot be conclusively established (Tracey et al., 2025). Second, the reliance on self-reported measures introduces the potential for response bias, including social desirability and recall bias. Patient satisfaction, in particular, is inherently subjective and may be influenced by factors beyond the scope of measured variables (Suprpto et al., 2025). Third, the

study was conducted across a limited number of primary care facilities, which may limit the generalizability of the findings to other settings with different organizational structures or resource levels. Contextual variability remains a critical factor in the implementation of health policy (Vianna et al., 2026).

Fourth, although multiple implementation dimensions were assessed, other potentially relevant factors, such as leadership, governance, and community engagement, were not explicitly included in the analytical model (Zuchowski et al., 2025).

Recommendations for Future Research

Future research should move beyond static cross-sectional assessments and prioritize designs capable of establishing temporal and causal inference. Longitudinal and quasi-experimental approaches, such as interrupted time-series or controlled before-and-after studies, are essential for capturing how changes in implementation intensity translate into sustained improvements in service quality and patient satisfaction. Equally important is integrating multilevel modeling to disentangle facility-level, provider-level, and patient-level effects, given that implementation operates across nested system layers. A second priority is the refinement of measurement. Current constructs of policy implementation should be operationalized with greater granularity, incorporating fidelity, dose, reach, and adaptation. Developing composite indices with validated weighting schemes would enable more precise estimation of which implementation components drive outcomes under varying resource constraints.

Third, future studies should explicitly model mediation and moderation pathways. For example, testing whether service quality mediates the relationship between implementation and satisfaction, or whether resource scarcity moderates these effects, would yield actionable insights for targeted interventions. Finally, research should be embedded within routine health system data ecosystems to enable scalability and policy responsiveness. Linking administrative data with patient-reported outcomes can facilitate real-time monitoring, allowing policymakers to iteratively adjust implementation strategies based on performance signals rather than periodic evaluations.

CONCLUSION

This study demonstrates that health policy implementation significantly influences both service quality and patient satisfaction in primary care settings. The findings confirm that higher levels of implementation, particularly policy adherence, resource availability, and provider compliance, are consistently associated with improved perceived service quality and greater patient satisfaction. These results directly address the study objective by establishing that policy effectiveness is determined not only by its design but by the extent to which it is operationalized at the service delivery level. Among the implementation components, policy adherence emerged as the most influential factor, indicating that strengthening execution fidelity should be prioritized within health systems. Resource availability and provider compliance also play critical roles, underscoring the need for investments in infrastructure, workforce capacity, and supervision mechanisms to maximize policy impact.

From a policy perspective, the findings highlight the need to shift focus from policy formulation to implementation strengthening. Evidence-based interventions should include routine monitoring of implementation fidelity, capacity-building for healthcare providers, and ensuring equitable resource distribution across primary care facilities. Such strategies are likely to produce measurable improvements in service quality and patient-centred outcomes, ultimately enhancing the overall performance of primary healthcare systems.

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Conflict of Interest

The authors declare that there are no conflicts of interest related to this study. The research was conducted in the absence of any financial or commercial relationships that could be construed as a potential conflict of interest.

Authors' Contributions

Anita Costanci Christine Tengker: Conceptualization; Methodology; Investigation; Writing – original draft. Supervision; Validation; Writing – review & editing; Project administration.

Nancy Sylvia Bawiling: Data curation; Formal analysis; Visualization; Writing – review & editing.

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