CLIENT'S PERCEIVED & EXPECTED SERVICE QUALITY OF PCU AT PARK PRIEW SUB-DISTRICT, SARABURI PROVINCE, THAILAND, 2005

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CLIENT'S PERCEIVED & EXPECTED SERVICE QUALITY OF PCU AT PARK PRIEW SUB-DISTRICT, SARABURI PROVINCE, THAILAND, 2005

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ABSTRACT

Under Thailand's new universal health insurance policy, the government has allotted a budget for the treatment expenses of the people who do not have any health insurance. It is very important to know whether the service that the people receive has quality or not. This cross-sectional descriptive research aimed to analyze the service quality of the primary care unit in Park Priew Sub-district, Amphur Muang, Saraburi Province, during March 1 - 15, 2005. A questionnaire, developed by the researcher having a reliability value of 0.97 and 0.93 in the expectation part and perception part was used for data collection from 263 people. Descriptive statistics, one way ANOVA, t-test and paired t-test were used for data analysis at the level of alpha = 0.05

The results showed that overall expectation and perception in service quality was at high level. There was a significant difference between expectation and perception in service quality, with the mean of 6.84 and 5.47 respectively ($p<0.05$) both overall and in each aspect of tangibles of service, reliability, responsiveness to the service users, assurance, and empathy. Moreover, it was found that people who were of different educational levels, who spent different amounts of traveling time from home to PCU, and who had different levels of health information received and different residence zones, had significant differences in expectations and perception of service quality ($p < 0.05$). But there were no differences among people who were of different gender, age, marital status, occupation, monthly average household income and frequency of service used.

The suggestions were that there should be improvement of service locations and materials that provide convenience, the improvement of public relations or information provided to the people to know the characteristics of service in the PCU, and the planning for the continuous competency development of human resources in terms of knowledge and understanding both in the PCU services and the primary care.

KEY WORDS: SERVICE QUALITY, PCU, HEALTH INSURANCE

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บทคัดย่อ

การสร้างหลักประกันสุขภาพถ้วนหน้าเป็นนโยบายที่สำคัญของประเทศไทย รัฐบาลได้สนับสนุนงบประมาณเพื่อเป็นค่าใช้จ่ายในการรักษาพยาบาลให้กับประชาชนที่ไม่มีหลักประกันสุขภาพใดๆ จึงจำเป็นอย่างยิ่งที่จะต้องรู้ว่าบริการที่ประชาชนได้รับนั้นมีคุณภาพหรือไม่ การวิจัยเชิงพรรณนานี้ มีวัตถุประสงค์เพื่อวิเคราะห์คุณภาพบริการของศูนย์สุขภาพชุมชน ตามความคาดหวังและการรับรู้ของประชาชน ณ ตำบลปากเพรียว อำเภอเมือง จังหวัดสระบุรี เก็บข้อมูลโดยใช้แบบสอบถามที่ผู้วิจัยสร้างขึ้น ที่มีค่าความเที่ยง 0.97 ในส่วนความคาดหวัง และ 0.93 ในส่วนการรับรู้ จากประชาชนตำบลปากเพรียว 263 คน ระหว่างวันที่ 1-15 มีนาคม 2548 วิเคราะห์ข้อมูลด้วยสถิติพรรณนา ค่าสถิติอโนวา ค่าสถิติที และ ค่าสถิติแพร์ที ที่ระดับแอลฟ่า = 0.05

ผลการวิจัย พบว่า ความคาดหวังและการรับรู้เกี่ยวกับคุณภาพบริการโดยรวมอยู่ในระดับมาก มีค่าเฉลี่ย 6.84 และ 5.47 (จากคะแนนเต็ม 7) ซึ่งมีความแตกต่างกันอย่างมีนัยสำคัญทางสถิติ ($P < 0.05$) ทั้งโดยรวมและจำแนกเป็นรายด้าน ได้แก่ ความเป็นรูปธรรมของบริการ ความเชื่อถือไว้วางใจได้ การตอบสนองต่อผู้รับบริการ การให้ความมั่นใจแก่ผู้รับบริการ และ ความเข้าใจและเห็นอกเห็นใจในผู้รับบริการ นอกจากนี้ยังพบว่าประชาชนที่มีระดับการศึกษา ระยะเวลาที่ใช้ในการเดินทางจากบ้านมาถึงศูนย์สุขภาพชุมชน การได้รับข้อมูลข่าวสารด้านสุขภาพและโซนที่อยู่อาศัย ที่ต่างกัน มีความคาดหวังและการรับรู้ เกี่ยวกับคุณภาพบริการแตกต่างกัน ($P < 0.05$) ส่วนประชาชนที่มี เพศ อายุ สถานภาพสมรส อาชีพ รายได้เฉลี่ยครอบครัวต่อเดือน และ จำนวนครั้งที่มารับบริการ ที่ต่างกัน มีความคาดหวังและการรับรู้เกี่ยวกับคุณภาพบริการ ไม่แตกต่างกัน

ได้เสนอแนะให้ ปรับปรุงสถานที่ให้บริการ และ สิ่งอำนวยความสะดวกต่างๆ ประชาสัมพันธ์หรือให้ข้อมูลข่าวสารให้ประชาชนได้ทราบถึงลักษณะของการบริการในศูนย์สุขภาพชุมชน และวางแผนพัฒนาศักยภาพของบุคลากรทุกระดับอย่างต่อเนื่อง ทั้งด้านความรู้ความเข้าใจในงานบริการของศูนย์สุขภาพชุมชน และความรู้ความเข้าใจในด้านงานบริการปฐมภูมิ

150 หน้า

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CHAPTER 1
INTRODUCTION

Background and Rationale

A Primary Care Unit (PCU) is the front line care giver of the health service system that the people can choose. It is close to people, the culture, and traditions in the community. It can provide closer service to the people than other hospital service centers or specialist institutes. A Primary Care Unit staff usually understands the expectations, needs and feelings of the people who use their services. They can provide them the service that is appropriate to the needs and conditions of the people. (Office of Health Care Reform Project, 2002: 14)

A characteristic of the service of a community health center / Primary Care Unit is its front line care. It has the responsibility to take care of the people's health before they get sick, when they are sick and until they recover, from the time they were born until they die. This includes the comprehensive service which concerns the physical, mental, and social factors in order to integrate services for every necessary aspect of the patient in terms of health promotion, disease prevention, treatment and rehabilitation. Moreover, it is the unit that coordinates and cooperates with other services, whether medical or social, including information linking when needed, to have maximum benefit to the people (Office of Health Care Reform Project, 2002: 16).

The Primary Care Unit (PCU) (based on mail merge at Sor Tor. 0215/52/Wor27, Ministry of Public Health by Dr. Winai Viriyakijja (The Permanent Secretary of Ministry of Public Health) is under the concept of "Close to the Home, Close to the Heart". This concept was developed to focus on the importance of the policy changes to the target achievement implementation of good health for the people. It should be noted that at least 25% of the total population cannot reach the

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necessary health service system in Thailand (Sanguan Nittayrampong, 1999: 25). The government then has a policy to build up the Comprehensive Health Assurance in line with the Health Service System reform and the movement in the private sector under the Democratic Kingdom of Thailand in 1997 B.E. as shown in figure 1.

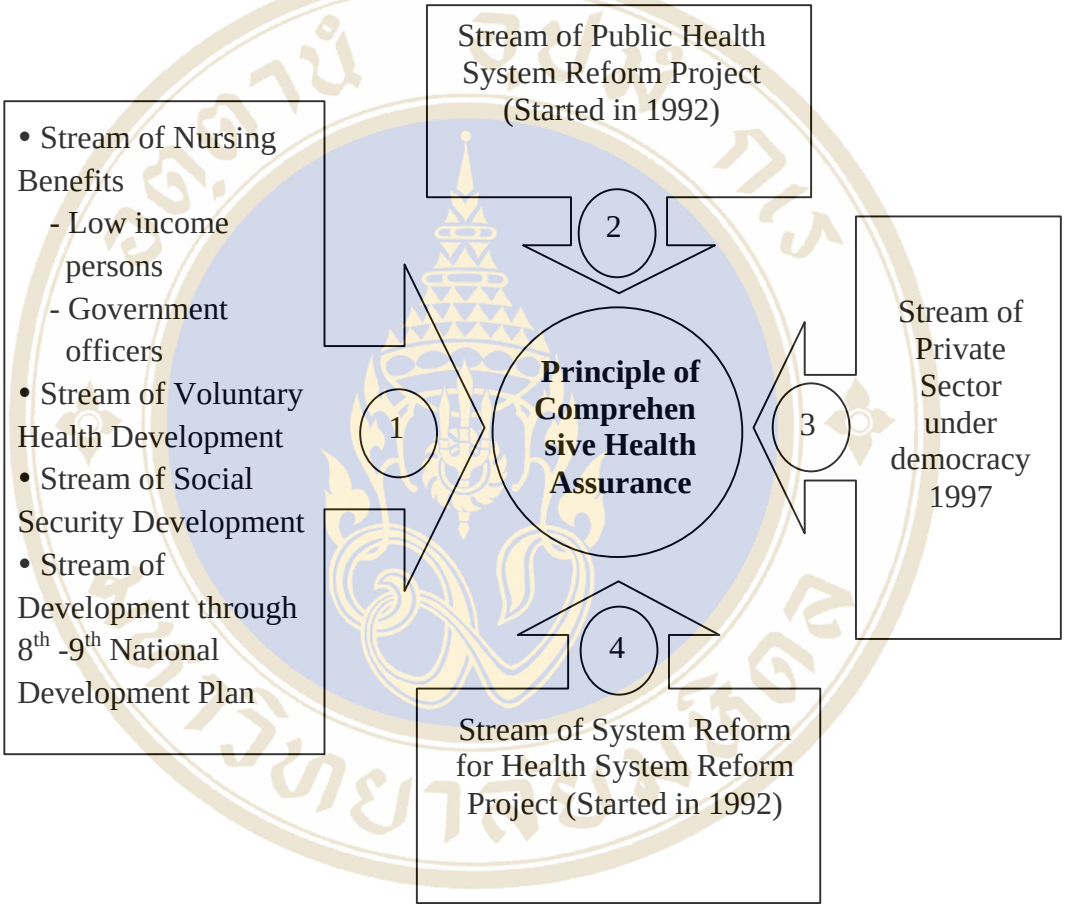

Figure 1 Rationale of Thailand's new universal health insurance policy
Source: Amphol Jindawattana and Suranee Pipatrojanakamol (2004: 21)

At present, the Ministry of Public Health has established the development of Community Health Centers / Primary Care Units need to have the same standard and social quality to respond to the needs, expectations, and feelings of the people who use the service according to the human rights that the people are entitled to. It was established in Thailand in 1997 B.E. and it is the core of an efficient health service system (Office of Health Care Reform Project, 2003: 14).

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In general, the problem of Primary Care Units implementation is that the service is not strong enough (Supatra Sriwanichchakorn, 2004: 28). The result of the establishment has not achieved its objectives (Pornthip Rattanavichai and et al, 2003: 18) and there is no productivity (Pakaporn Soponodorn, Ref. in National Health Security Office, 2004: 99). It could be said that it works like a screening unit for other service centers without developing uniqueness or value for the job, and there is no integration to have the entire factor comprehensive care (Supatra Sriwanichchakorn, 2004: 28 and Penkhae Larpying Ref. in National Health Security Office, 2004: 116). Moreover, there is an overlap zone service without transferal system (Boonsong Chamnarnprai et al., 2004: 31). The problems can be categorized into 5 aspects. In the quantity aspect it was found that the quantity of the patients who used the service had an increasing trend every year (Thailand Development Research Institute Foundation, 2004: 196 and Sanikarn Srimanee, 2002: 5). In the aspect of service, it was observed that service quality was low (Supatra Sriwanichchakorn, 2004: 28) and could not reach the standard (Bussaba Buaphan and Damrong Rattanawayne, 2003: 43, Pronthip Rattanawichai et.al, 2003: 18 and Wanwipa Jansorn, 2002: 263). Almost PCU's did not reach the PCU standard (Suphanburi Provincial Public Health Office, 2003: 17) and it was noted that there was no continuous treatment follow-up (Sanikarn Srimanee: 2004: 75). Moreover, the transferal system was not smooth (Supatra Sriwanichchakorn: 2004: 28). Concerning time, it was noted that the time while they are waiting for treatment and to receive the medication is too long (Vasinee singsa, 2003: 106). In the aspect of satisfaction, it was found that service users, who are the patients and relatives, were not satisfied with the service starting from reception, registration, queuing for treatment, explanation, medication and making appointment (Bang –On Konglang Ref. in National Health Security Office, 2004: 42, Bussaba Buaphan and Damrong Rattanawayne, 2003: 43 and Sanikarn Srimanee, 2004: 45). Staff and administrators were not satisfied with the service that was provided for the patients in the primary stage (Surat Pholbutr, 2004: 16, Poolsith Sritikarn et. al, 2002: 13, Yannapat Songyen, 2002: 45 and Srikalaya Wutthinanchai Ref. in National Health Security Office , 2002: 102). In the economic aspect, it was revealed that the distribution of resources, whether human, money, or material, of the

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Community Health Center / Primary Care Unit were not appropriate (Surat Pholbutr, 2002: 16).

The above mentioned problems have caused advance effects in the following aspects: To the patients and family, people do not realize their health problems and cannot cooperate while the patients still have diseases that can be prevented and have complications from chronic diseases. Moreover, it serves to cure rather than promote health. To the service providers, there is the lack of trust and belief from the people, society and superiors. Eventually, they lack of motivation and lack pride in themselves, the job and organization that they work for. This causes the officers not to satisfy and not to pay attention to the organization (Amphol Jindawattana and Suranee Pipatrojjanakamol, 2004: 191, Supattara Sriwanichchakorn, 2004: 28 Srikalaya Wutthinanchai Ref. in National Health Security Office, 2004: 102). It is a vicious cycle that may cause continuous problems. To the organization, the people lack of confidence in the quality of Primary Care Unit (Public Health Research Institute, 2004:1-3). People have less confidence and start looking for services from other districts without proper transfer (Boonsong Chamnarnprai and et.al, 2004: 31). To the country, the government increases allocation of a huge amount of budget for public health. However, the increased budget so far cannot solve the problems and cannot respond to the needs of the people.

According to the above mentioned problems, the causes of the problems that are very important can be analyzed into 4 aspects as follows:

Nature of the job aspect consists of the characteristics of the job at the Community Health Center / Primary Care Unit. It is a job that is close to the people. It entails to know the culture and traditions of the people in the community under its control better than other service centers such as hospitals or specialist institutes. It must understand the expectations, needs and real feelings of the people (Office of Health Care Reform Project, 2002: 14). Therefore, it needs cooperation from the community and related organization. People do not recognize the importance of health promotion and do not have strong leaders, which makes health promotion very difficult and thus do not achieve its targets as it should be (Ministry of Public Health, 2003: 191).

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Staff aspect, the staff in the health centers such as doctors, nurses and medical workers are inadequate for service. Staff who work in the hospital have job overload (Ministry of Public Health, 2003: 22,191, Public Health System Research Institute, 2003:1-3, Supattra Sriwanicchakorn, 2004: 26-29, Sanikarn Srimanee, 2004: 5, Thailand Development Research Institute Foundation, 2004: 196, Pussadee Sutthawej Ref. in National Health Security Office, 2004: 104, Poolsit Sritisarn et.al. 2002:13 and Penkhae Larpying Ref. in National Health Security Office, 2004: 116) and it has been found that the service behaviors are not good, not impressive, and inappropriate words are used with the patients and relatives (Bussaba Buaphan and Damring Rattanawayne, 2003: 43, Vasinee singsa 2003:106 and Sanikarn Srimanee, 2004: 43). Moreover, it has been observed that service providers were lack of knowledge and misunderstanding in Primary Care Unit implementation because they use the traditional management and service structures of the Ministry of Public Health as a principle. There is no new organization setting. Knowledge base and past experience are used as the basis of working. According to the rapid expansion for nationwide operation, staff training only explains the standard policy of working and primary guidance while the concepts and principles were not well explained (Supattra Sriwannichakorn, 2004: 26-29 and Srikalaya Wutthinanchai, 2002: 102). Moreover, it has been noted that service providers could not respond to the community needs (Public Health Research Institute, 2003:1-3).

For equipment, it has been revealed that equipment and tools and medication are inadequate, out of date and not ready to use (Pussadee Sutthawej, 2002: 1-4, Lopburi Provincial Public Health Office, 2003: 18 and Sanikarn Srimanee, 2004: 75). For finance and budget used for the implementation is not sufficient (Public Health System Research Institute, 2003:1-3). In the distribution of the budget, it has been found that the transfer of the budget to the department is slow, which cause the budget not to follow the plan (Ministry of Public Health, 2003: 22,191). Moreover, public health centers in many provinces try to pay the budget so that the distribution of the budget is different from the objectives of the project (Thailand Development Research Institute Foundation, 2003: 186-189). It has also been observed that the budget distribution is used for treatment rather than for diseases prevention or for health promotion (Public Health Research Institute: 2003: 1-3).

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In the aspect of working system, there is a lack of a good working system and support for the implementation, lack of clear and appropriate planning, organization setting and implementation is not appropriate, command line is not clear, job assignment is unclear and inappropriate (Ministry of Public Health, 2003: 22, 191, Pussadee Sutthawej, 2002: 1-4 and Penkhae Larpying Ref. in National Health Security Office, 2004: 116), especially for the hospital officers who work at PCU with the existing officers. Moreover, many health centers depend on 2-3 CUP's. It is not clear whether they should separate CUP's according to the ruling districts or under other standards (Thailand Development Research Institute Foundation, 2003: 186), there is a lack of working procedure under the right principles and standards (Penkhae Larpying Ref. in National Health Security Office, 2004: 116), lack of efficient cooperation and transfer (Pornthip Rattanawichai et.al: 18 and Surat Pholbutr, 2004: 16) there is no regular staff (Public Health System Research Institute, 2003: 1-3), data collection is not correct and is not complete (Pussadee Sutthawej Ref. in National Health Security Office, 2004: 104) lack of data and support information in implementation including operation manual (Ministry of Public Health, 2003: 22, 191). Report in the extent of the problems is not detailed and is incomplete and there is no treatment assessment (Suphanburi Provincial Public Health Office, 2003: 17 and Sanikarn Srimanee, 2004: 5) Orientation trainers follow-up and assess but do not understand the principle of Primary Care Unit implementation (Supattra Sriwanichchakron, 2004: 26-29). In the aspect of policy, it has been found that the policies changed periodically (Public Health Reasearch Institute, 2003: 1-3), which caused the hospital had to adjust working processes every year, which also created confusion and lack of confidence in working (Supattra Sriwanichchakron, 2004: 26-29). This included the urgent policies to respond to the patients which had to be finished according to the plan, which caused the routine/normal work to finish later than established in the plan (Ministry of Public Health. 2003: 22, 191).

According to the analysis of the problems and causes of the problems in the Primary Care Unit, it was found that the most efficient problem solving is by solving the problem from its cause (Somchart Torugsa, 2003: 82-83) but there are a lot of causes of the problem with limited resources. Researcher has chosen to solve the problem by assessing the results of the service quality to examine the result of service

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management. The concept of quality and manufacturing improvement considers quality as a business strategy which is of highest business importance. Every successful organization establishes quality as the highest goal of the firm (Surasak Nananukool et.al, 1995: 111). Moreover, service quality is important to attain because getting good service and ethics of the profession is beneficial to the health of the people. However, the kind of service quality is up to the decision and service of the provider. At the same time, customers have needs and expectation of higher quality. Therefore, the health service provider must adjust themselves to improve the service quality continuously. Any firm or organization that does not pay attention to improve its service will negatively affect its image. Service quality is up to the perception of the customers to the service, whether the service responds to their needs and expectations. If the customers get the service according to their expectations, they will be satisfied with the service. Quality is established by the customer or patient (Mc Nealy, 1993).

Customers do not know how to assess the service quality according to the professional standards. Quality standard from their own point of view is assessed while they are interacting with the service provider. In other words, to use interactive standard for assessment (Kotler, 1994 and Bopp, 1993), which is the same concept as Anuwat Supchutikul (1993) who said that the standard of professional quality is only one of the qualities and not the only quality because patients who use the service do not care what kind of service standard that the hospital has. They are interested only when they use the service. Will they get it according to their expectations or not? How is the treatment? Is the relationship among service providers and service users pleasant and satisfactory for both sides? Thus the service that they provide has to be a high quality according to the perception of the service users.

However, the service quality in this study was measured based on the satisfaction from the perception of the service users. Only perception does not cover the meaning of “Quality” completely even though the perception of the patient will be useful information. However, using expectation to study compared with perception will reveal wishes and needs much more than only perception (Scandina, 1994). The comparative feeling will happen when they use the service.

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Parasuraman, Ziethaml and Berry (1993) used the concept of service quality by measuring the satisfaction from perception and expectation, they developed standard tools to measure service quality. It also has implementation steps that are acceptable.

Therefore, researcher was interested in studying the service quality according to the expectation and perception of the service users by using the service quality concept of Zeithaml (Zeithaml et al., 1990) in order to assess service quality which is composed of 5 factors: Tangibles of service, reliability, responsiveness to the patient, assurance, and empathy towards the patient. It seeks to analyze service quality of a Primary Care Unit in urban area of Saraburi Province. It is the service unit of a main contractor of Saraburi Hospital under the control of the Ministry of Public Health to have a standard and social quality, to respond to the expectations and feelings of the people of Park Priew Sub-district who use the service to transform the comprehensive health care to achieve its targets.

According to Saraburi Hospital, which is the regional hospital under the control of the Ministry of Public Health with 680 beds, it is the major network hospital that should be the role model for the network hospitals in 5 other provinces which are: Suphanburi, Singhaburi, Chainart, Nakornnayok and Lopburi. Moreover, there is another network that they have to be responsible for, which is the 27-PCU network of Saraburi Hospital. Based on the satisfaction survey of the service users of the Out patient Department and Primary Care Unit in the past year (2003-2004 B.E.), the problems of the unit were found in the aspect of quantity of work, service quality, service timing, and satisfaction of the concerning persons to the Outpatient Service and Primary Care Unit implementation. The economic aspect is similar to the OPD and primary care unit in the other hospitals. Even though the problems are being solved, the mentioned problems still exist until now. In the 9th Health Development Plan in 2002-2006, the quality standard of the service station in each level was established by focusing on the quality system to reach international standards. The entire system shall be examine to get appropriate concepts and application of all PCU of Saraburi Hospital, PCU of Saraburi province and nationwide PCU. The results of this study will serve as a guide for the administrators and implementers to use in creating the plan for the improvement of the service quality continuously.

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Research Objectives

General Objectives

To analyze the service quality through the expectations and perceptions of the service users in a Primary Care Unit in urban area of Saraburi Province.

Specific Objectives

1. To measure the service quality through the expectations and perceptions of the service users in a Primary Care Unit at Park Priew Sub-district, Amphur Muang, Saraburi Province.
2. To analyze the differences of service quality between the expectations and the perceptions of the service users.
3. To analyze the differences of service quality by the characteristics of the service users which are: gender, age, marital status, education, occupation, monthly average income, frequency of service use, information received, traveling time from house to PCU and residence zone.

Research Hypothesis

1. The service quality through the expectations and perceptions of the service users in a Primary Care Unit at Park Priew Sub-district, Amphur Muang, Saraburi Province are different.
2. The service users who have different characteristics such as gender, age, marital status, education, occupation, monthly average income, frequency of service use, information received, Traveling time from house to PCU and residence zone have different expectations in service quality.
3. Service users who have different characteristics such as gender, age, marital status, education, occupation, monthly average income, frequency of service use, information received, Traveling time from house to PCU and different resident zones have different perceptions of service quality.

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Scope of the Research

1. This research focused only on the service of the Primary Care Unit in the Urban Area at Saraburi Hospital in Saraburi province only.

2. The research period was from March 1-31, 2005.

Research Assumption

This research analyzed the service quality of the Primary Care Unit in the urban area of Saraburi by using the concept of Zeithaml et al. (1990)

Research Variables

Variables of the study are as follows:

1. Independent variables are the characteristics of service users such as gender, age, marital status, education, career, monthly average income, frequency of service use, traveling time from house to PCU, information received and residence zone.

2. Dependent variables are the expectations and the perception about the service quality of the service user. Both are composed of 5 aspects as follows:

2.1 Tangibles

2.2 Reliability

2.3 Responsiveness

2.4 Assurance

2.5 Empathy

Conceptual framework of the research

According to the service quality expectation and perception, the conceptual framework of the research is as follow:

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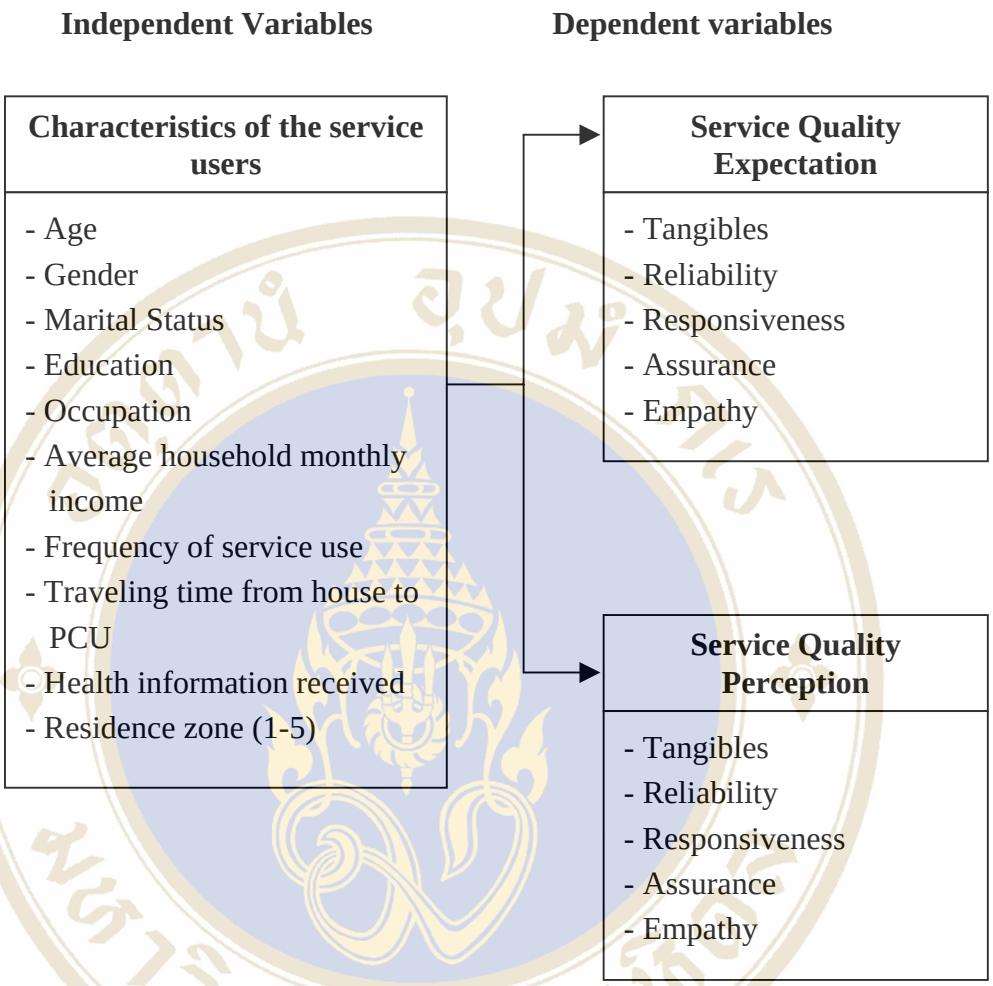

Figure 2 Conceptual Framework of this study

Definition of Terms

1. People means the heads of families or representatives who are men or women who reside in Park Priew Sub-district, Amphur Muang, Saraburi (Urban Area) and must be 15 years old or above and are conscious and willing to answer the questionnaire.

2. Community Health Center/ Primary Care Unit means first stage service center that people can reach conveniently for the health care of people of every age. It provides service continuously and covers treatment, rehabilitation health promotion and disease prevention. One Primary Care Unit is responsible for 10,000 people.

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They have doctors, professional nurses and other officers based on the established standards. A Primary Care Unit can be divided into 3 types as follows:

2.1 Primary Care Unit Type 1 means an operation unit that is a health center or previous service center that was developed to have higher ability but with no additional doctors and nurses to join for service.

2.2 Primary Care Unit Type 2 means an operation unit which is a health center or service center that was developed from the first level but has professional nurses and dentists who provide regular service but the doctor is only present sometimes.

2.3 Primary Care Unit Type 3 means an operation unit which has doctors, professional nurses and public health officers who work regularly and is complete as it has been established according to the standards.

In this research, the Primary Care Unit is Type 3 which is the Primary Care Unit in nursing and public health in urban area of Saraburi Province was studied. It is responsible for service management in responding to the needs of the people's health in Park Priew Sub-district at the fundamental level which has continuous combined health activities. People can reach the services conveniently and have a system for consultation and transfer. All of its service helps to promote the health and strengthen the people of Park Priew Sub-district to prevent or reduce the problems whether physical, mental or social, with the people's participation. For the convenience in health care, the responsibility areas were separated into 5 zones.

1. Health information receiving means the Park Priew people are notified in the community at the same level in the Primary Care Unit of the hospital through advertising as well as public relations, such as communication from the service providers directly to the service users to get data about service quality. If the communication is not the same as the actual service, it will make the service users disappointed and assess the service to be of no quality.

2. Frequency of service use means the number of times that people of Park Priew use the service at the Primary Care Unit of Saraburi Hospital, which is categorized into more than 10 times and less than 10 times.

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3. Traveling time means the time that they travel from home to the Primary Care Unit in the Urban Area, Saraburi Hospital, calculated in minutes and categorized into 1-10 minutes, 11-20 minutes and 20-30 minutes

4. Residence zone means area in Park Priew Sub-district, separated into 5 zones by characteristics of geographic and Each zone has different characteristics as follows 1. Area 2. The distance from the Primary Care Unit 3. Big picture of social condition 4. Private Health Clinics 5. Community board Village and primary Health Volunteers 6. Coordination between people and the zone officer 7. Number of households 8. Number of communities 9. Number of service providers 10. Command line, main mission for the Primary Care Unit officers in the Urban Area to work conveniently.

Definition of Variables

1. Service quality means ability to respond to the needs or expectation of the service users of the work in the Primary Care Unit in the urban area, Saraburi Hospital by using the assessment standard concept of Zeithaml et al., 1990, which consists of 5 aspects of service quality as follows:

1.1 Tangibles mean the physical service that can show convenience, such as equipment, staff and symbols used or documents that are used to communicate to the service users that they can touch, and it is service that is concrete.

1.2 Reliability means ability for service to be the same as the commitment to the service users. The service should be honest, appropriate and stable every time to make the service user feel that the service is credible and trustworthy.

1.3 Responsiveness means readiness and willingness of the service provider for the service, which can respond to the service users' needs immediately. Service users can obtain the service easily. The service must also be spread out broadly, quickly and with a short waiting time.

1.4 Assurance means service provider must have the skills, knowledge and ability in service and can respond to the needs of the service users politely, with

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good words and good manners. This can be built in the service users the trust and assurance that they will get the best service.

1.5 Empathy towards the service user means the ability to take care of the service users according to the different needs of each person.

2. Expectation of the people about service quality means the needs, feelings or ideas and awareness of the people in Park Priew to the Primary Care Unit in the Urban Area, Saraburi Hospital in forecasting in advance that the quality service that it should have, or should be, or should happen that is appropriate to the status or conditions at that time, which can be measured by 5 aspects of expectation measurement standard which are tangibility of service, reliability, responsiveness to the service users, assurance of the service user and empathy to the service user.

3. Perception of the people about service quality means responsive of the people of Park Priew who obtain the service and understanding it through their senses, after using the service from the Primary Care Unit in the urban area, Saraburi Hospital, which can be measured by 5 aspects of expectation measurement standard which are tangibility of service, reliability, responsiveness to the service users, assurance to the service user and empathy towards the service user.

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CHAPTER 2
LITERATURE REVIEW

In the study of "Client's Percieved & Expected Service Quality of Primary Care Unit at Park Priew Sub-district, Saraburi Province, Thailand, 2005", the concepts, theories, and related researches were reviewed and concluded in 2 following part:

Part 1: Related literature about Primary Care Unit

1.1 Definition and importance of the Primary Care Unit.

1.2 Problems of the Primary Care Unit (problems, outcomes, causes and solutions)

Part 2: Literatures that are related to each variable (definition, factors, effective factors)

2.1 Service Quality.

2.2 Expectation of service users about service quality.

2.3 Perception of service users about service quality.

2.4 Related researches.

Part 1: Related literature about Primary Care Unit

1.1 Definition and importance of the Primary Care Unit.

The Bureau of Health Service System Development (2004: 2) mentioned that Primary Care Unit means a unit that has the responsibility and obligation in providing the service to respond to the fundamental health needs of the people. It is related to the health activities in mixed composition. People can reach the service conveniently and it provides consultation and transfer services for the health promotion and strengthening of the people to prevent or reduce physical, mental, or social problems with the people's participation.

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Suparttra Sriwanichchakorn (2004: 17) mentioned that the core of a Primary Care Unit is not focused on the medical aspect only, but also focuses on integration of medical expertise to apply to the actual life of the people and make health care a joint effort among people and public health staff appropriately. It focuses on the concept of a total framework which understands the factors and conditions that affect health. This means that the value of a job can not be measured by medical standards only.

Sanikarn Srimanee (2004: 17) mentioned that a Primary Care Unit means space management in the building or setting the building separately and following the composition of human resources, equipment, physical materials, and working system to establish primary care. At present, PCU or Primary Care Unit as it is called by Ministry of Public Health, is established to be the center of the community and for the people to have a sense of ownership.

Office of Health Care Reform Project (2002: 15) mentioned that the unique role of the Primary Care Unit is to be responsible for the health of the people continuously, together with the people for health care service with the concept of close service and close to the home, to create a friendly climate among users and service providers which is close to the people. It is also a system that opens the opportunities to the service users and service providers to know each other. The staff has the potential and ability to apply its medical knowledge for the service to be well in line with the social and psychological conditions of the people. It has a system management which is responsible for health care, with the public health officers and the people working together continuously to promote health along with nursing treatment.

According to the above-mentioned concept, it is concluded that the definition of Primary Care Unit is a health care center that has close relationship with the people. It has a responsibility to respond to the fundamental people's health needs which is linked to the health activities in the mixed firm. People can reach the service conveniently and has a consultation and transfer system to prevent or reduce the

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physical and mental problems and be able to get along with the social and psychological conditions of the people. It has a system management which is responsible for health care, with the public health officers and the people working together continuously to promote health along with treatment.

A characteristic of the service of a Primary Care Unit is to give importance to the service users with the principle to respond to the needs of the people as a center, which makes the health promotion of this unit have some characteristics that need to be developed (Office of Health Care Reform Project, 2002: 16) which are:

1. To have an obligation as a unit which is responsible for the health of the people with people's participation People who have good health know how to treat themselves in the appropriate way and choose the health service system in a balanced manner (which has a service and non-service role).

2. To have an obligation as the front line care to reach the people to use the service and be able to take care of the people's health in every age group and every disease group that may vary according to the important problems and conditions of the people. To be a health consultant for the people before getting special services.

3. To provide ongoing/longitudinal care for the people's health from the time they get ill to rehabilitation and from birth to death. This includes understanding and knowledge between people and service providers continuously.

4. To provide comprehensive care, which is concerned with physical, mental, social and related economic factors, according to the needs of the service user whether in health promotion, disease prevention, nursing or rehabilitation.

5. To be the Co-ordinate Care Unit which transfers and coordinates with other services, whether in medical or social when necessary, as well as information linking to offer maximum benefit to the community.

The National Health Security Office emphasizes importance of having and using the Primary Care Unit as the front line care giver which has the obligation

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to provide comprehensive service (whether in treatment, health promotion, disease prevention or rehabilitation). In cases that are beyond its ability, the service center will be responsible for transferring the patient to other Primary Care Units and other levels of health service such as Secondary Care Units and Tertiary Care Units that provide service within the network. It can be the public network or the network between the public and private sector.

The Health Service System under the universal health insurance policy has established that a Primary Care Unit network that can register the people must be able to provide comprehensive care whether in treatment, health promotion, disease prevention or rehabilitation, whether internal or external service. They must have at least 1 doctor with other officers as service providers. At present, where people can register are Community Hospitals, City Public Health Centers and Community Doctor Centers (which have doctors who practice regularly, hospitals, health stations and private clinics (which have full time doctors).

Large hospitals can also be the primary service providers and can register the people. They have to set the system that can provide comprehensive service under the established regulations.

To be able to operate with the universal health insurance policy under the established regulations, it was considered that all of the public hospital should have the standard service from the beginning. The private hospitals must pass the primary standard regulation assessment before joining the service.

Private hospitals that would like to provide primary care must set up the system that can provide comprehensive care under the established regulations.

An important and unique feature of the Primary Care Unit is that it is the front line care of the health service system in which the people who use the service can have a close relationship. It knows the traditions, culture and society of the people in the community that they are responsible better than hospitals or

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specialist institutes. Therefore, service in this unit should have social quality to understand the needs, expectations, and feelings of the people who use the service better than other units and be able to apply medical knowledge to be in line with the needs, economic conditions and culture of the people. It can communicate for understanding. It has an obligation to build up the potential of the people in order to take care of their health appropriately. So that they can stand on their own legs and rely on the service system.

Therefore, it is necessary to set the Primary Care Unit as the health service center close to home and close to the heart, and create a friendly climate for the service users. There must be a system that allows the service provider and service user get to know each other. The staff has the ability to apply their medical expertise to provide service to be in line with the cultural, social and psychological conditions of the people. It must establish the responsibility to take care of the health of the people continuosly through the people and public health officers working together, as well as to build up health along with nursing treatment.

Primary Care Units under the universal health insurance policy does not mean the service unit that provides only nursing service or selected services, and it is not an extended OPD, but it aims to have a role in taking care of the people's health condition that focuses on health promotion and service provision to have more quality to respond to the people's health needs. This includes the establishment of a comprehensive service that is the service which is responsible with the mental, social and economic factors of the people in its area of responsibility.

This research studied only the Primary Care Unit in Saraburi Hospital which is a single unit that has complete service under standard regulations. The service users will come to the Primary Care Unit in the Urban Area of Saraburi Hospital which has a separate diagnosis too. Although many people use the service, PCU will provide services only the patients in Park Priew Sub-district (Urban Area) Amphur Muang, Saraburi , office hours are from 8.30 -12.00.

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Type of Primary Care Units can be classified into 3 types:

1. Type 1 Primary Care Unit which is a health center or existing service center without additional doctors and nurses to join the service.

2. Type 2 Primary Care Unit which is a health center or existing service center which has been developed from Type 1 and has a professional nurse and dentist who regularly practice at the center, a doctor work with the center for sometimes.

3. Type 3 Primary Care Unit which is the operation unit that has doctors, professional nurses and public health center officers who work fulltime.

Saraburi province established the Primary Care Unit in October 2001 by setting up the Primary Care Unit at the district according to the format, target and standard regulations of Primary Care Units in the provincial level under the Ministry of Public Health. The Public Health office will operate and set up supporting activities for the participating unit. The major contracting hospital has the freedom to make a decision and plan to set up the Primary Care Unit. In the first year of establishment, one Primary Care Unit in the major contracting hospital has to be established and then at least one Primary Care Units outside the hospital should be established and then is to expand to all of the areas in 5 years.

Implementation of Primary Care Unit in the Urban Area of Saraburi Hospital

1. Separated responsible areas of Park Priew Sub-district were divided into 5 zones for convenience in implementation. In each zone, officer will be responsible for the primary service whether in promotion, prevention, treatment or rehabilitation. Each zone has different characteristics as follows:

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Table 1 Summary characteristics of Zone 1-5

Characteristics	Zone				
	1	2	3	4	5
Area	North of Pa Sak River on the left side of Phahon Yo Thin Rd.	North of Pa Sak River on the right side of Phahon Yo Thin Rd.	On the side of railway and Pa Sak River, on the right of Phahon Yo Thin Rd.	On the side of railway and Pa Sak River on the left of Phahon Yo Thin Rd.	Below South of railway.
The distance from the Primary Care Unit	Far	Very Far	Medium	Far	Far
Big picture of social condition	City and up country society	City and up country society	City society, Market, shop	Mostly up country society	City society
Private Health Clinics	Some	Some	Many	A little	Medium
Community board Village Health Volunteers	Clear and strong	Clear	Little, strong	Clear and strong	Clear and strong
Coordination between people and the zone officer	Some	More	Least	Most	Little

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Table 1 Summary characteristics of Zone 1-5 (Cont.)

Characteristics	Zone				
	1	**2**	**3**	**4**	**5**
Number of households	2,800	2,078	550	1,527	1,553
Number of communities	4	2	2	6	9
Number of service providers	5	3.5	2.5	4	
Command line, main mission	Social Medicine Department, CD job and PCU	Social MedicineDepartment, NCD job and PCU	Social Medicine Department, Health promotion and PCU	Nursing departmen, PCU	

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Figure 3 Map of the 5 separates zones in Park Priew Sub-district.

2. Outpatient service at the Primary Care Unit.

2.1 Services are provided to general patients and chronic patients who are in Park Priew whether they carry a Gold Card, government officer card, or no other card except Social Security card. The registration Officer is the one who screens and transfers the patients.

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2.2 Patients in the responsibility area are at the clinic for follow up where the specialist doctor sees whether there are no complications and patient is willing to have appointment to be treated at the Primary Care Unit to have a primary care of the patient such as those with DM or Hypertension.

2.3 When the service system is well organized, it can expand the service to special clinics such as Well-Baby or ANC for the complete primary care service.

2.4 Doctors and service users will examine the patient who come to receive service for the general disease on that day. In case of chronic patients who have a follow-up appointment, they will have an appointment on the same day of the patient's zone shift.

2.5 Service will open only in the morning while the zone doctor is on the treatment shift and the afternoon is not for the service.

2.6 Medical record documents that are used are OPD card and Family History folder.

1.2 Problems of Primary Care Unit service implementation

Somchart Torugsa (2003: 8) mentioned that the problems of any work are incompleteness. There are differences between the expectations of the actual hospital service whether in patient service, administration or academic aspect,which are not as good as the patients', hospital administrators' and hospital officers'expectation, etc. Service users get less service, low service quality, are not satisfied with the service that they receive from service at any service point, etc. It results in service with less efficiency, which means getting less results when compared with the use of resources.

Supattra Sriwannichchakorn (2004: 9, 28, 33-36) stated that the service system that is the front line care of the health service system has low quality. The Primary Care Unit did not receive full support and development and transfer system was not smooth. Moreover, they had the obligation as the service screening department for other service units without development to have uniqueness or value

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for the job, no concept integration and development to provide the comprehensive health.

Sanikarn Srimanee (2004: 75) conducted a research on “Factors that are related to satisfaction of the service user who use the Primary Care Unit in Saraburi.” It was found that problems and obstacles of those who used the service at the Primary Care Unit was that most of them (25.63%) did not have adequate and had old-fashioned materials and medical equipment in order to provide the service, there was a lack of follow-up of diagnosis from the doctor (21.25%). Moreover, it was found that 16.88% had problems in the words used and the friendly action of the nurses who provided the service.

Sanikarn Srimanee (2004: 5) surveyed the number of persons who used the service at the Primary Care Unit in Saraburi and found that the number of patients who used the service from January 2002 until May 2002 had an increasing in trend, that resulted in many problems at the Primary Care Unit such as lack of staff, this can make users unsatisfied with the service.

Vasinee singsa (2004: iv) studied the research factors that are related to the service quality perception of primary care service of those who use the service at OPD under the Comprehensive Health Assurance policy in Nonthaburi. It was found that the service users had the most problems in long time waiting for the diagnosis (31.2%); next was the long time waiting to receive the medicine (24.1%); doctors had less time to diagnose the patient (18.4%); receptionist had bad manners (12.5%); slower card issue, (9.1%); and many steps of service processes (2.5%).

Lopburi Provincial Public Health office. (2003: 18) assessed the satisfaction of the people who used the service at the Public Health Center in 5 aspects and found that people had the least satisfaction in the aspects of readiness and timeliness of treatment.

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Suphanburi Provincial Public Health Office (2003: 17) surveyed and assessed the quality of PCU's and Health Centers. It was revealed that the PCU's which reached the 70%, standard regulations, which were 12 out of 39 PCU's, or 30.76%.

Bang-Orn Kon Kalng (2003: 42) studied the service quality according to the expectation and perception of service users of the Comprehensive Health Assurance Project to the Infectious Disease Hospital in the Northeastern region of Khon Kean province from 230 service users, by using systematic random by chance. The results showed that service quality according to expectation and perception of the service users were significantly different. It means that the expectation of the service users, who used the primary care service, towards the service quality was much more than the service they received.

Bussaba Buaphan and Damrong Rattanawayne (2003: 43) studied the result of implementation of 30 baht project at the Primary Care Unit. Officers' behavior in providing service, knowledge and understanding about rights and benefits of the officers were assessed. Sample group consisted of 34 public health officers who worked at the Primary Care Unit are patients who came for or used the service at the Primary Care Unit, the questionnaire to collect data was studied. The results revealed that the aspect that they wanted the Primary Care Unit to improve most was talking and manners. Service establishment at the Primary Care Unit does not reach established standard especially in autopsy, delivery, and in the part of registration of those who have the 30 baht privilege.

Pornthip Rattanawichai (2003: 18) studied the service activities of 3 Primary Care Units in Pijit that had doctors, public health center officers, dentists and pharmacists who worked in the Primary Care Unit. Data was collected from 50 subject using a questionnaire. The results showed that doctors, dentists, pharmacists and nurses had activities in health promotion, rehabilitation, prevention and disease control. Overall operation was only to provide service in treatment. For problems and obstacles in the service, most of them were the administrative problems especially the

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unclear roles, lack of coordination with the community organization, lack of coordination among the health teams. In the aspects of human resources, staff were few and did not have time to provide the knowledge to the service users. The equipment was also inadequate. The budget was low.

Surat Pholbutr (2004: 16) studied the opinion of the public health staff towards the health service according to the Comprehensive Health Assurance. Data were collected by using the questionnaire from 117 public health officers who worked at the Primary Care Unit in Petchburi province. It was found that the public health staff had different opinions about the Comprehensive Health Assurance Project. Their satisfaction towards the structure and management and service aspects differed. The ones who agreed to continue the project had more satisfaction in the job much more than the ones who disagreed. For the opinion in terms of transfer, a transferral system should be developed. Moreover, it was found that the problems of coordination within some network which lacked efficient coordination in human resources budget and medication.

Poolsit Seetisarn, et al. (2002: 13) studied the result of the Comprehensive Health Assurance Project and assessed the progress and efficiency of the project implementation by studying from related reports and the result of a satisfaction survey of the people who had a gold card, outpatients who used the service at Primary Care Unit and officers who implemented the project at the Primary Care Unit. The results showed that the staff preparation to support the Primary Care Unit was not yet enough because some of the implementers did not pass the training. For satisfaction aspects, 43.03% of outpatient were very satisfied and the least 0.14 especially in the convenience and fast in using service, manners of the officers, and implementation officers had low level satisfaction.

Boonsong Chamnarnprai et al. (2003: 31) studied “the financial situation and health service of the Comprehensive Health Assurance Project in Pissanuloke in 2003.” The results revealed that the overall most of health center had good financial status. The number of those who used the other district services

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without the transfer system were still higher than the ones who used the transfer system. The results reflected that the setting up of health center that are close to home close to heart has not achieved its objectives.

Yannapat Songyen (2002: 244) studied the satisfaction of the service user at the Primary Care Unit, Nangmud district, Amphur Garbcherng, Surin. It was a descriptive study. The study population consisted of those who were 15 years old and above which used the service at the Community Health Service. A total of 387 samples were studied. The data collection method was interview. The results showed that the mean of overall satisfaction was 80.1% and the satisfaction in staff was 72.63%.

Wanwipa Jansorn (2002: 263) studied the implementation by the standard of Primary Care Unit's officer in Amphur Muaklek and Amphur Nongkae, Saraburi. It was a descriptive study. The sample was 98 health center officers. The results recommended visiting the house to assess the basic conditions, to visit chronic patients and target groups continuously and offer treatment follow-up for the patients who had health problems to be transferred or diagnosed.

Pakaporn Soponnodorn (2004: 99) studied the productivity of the Comprehensive Health Assurance Policy implementation in 4 hospitals including Maharajnakron Chiengmai Hospital, Nakorn Chiengmai Tessabarn Hospital, McCormick Hospital and Cheingmai Ram 2 Hospital. The results showed that implementing the policy was quite productive based on 3 indices of productivity index, which are: first convenience for the service user to receive service second is the service that they provide to the users should be equal to everyone not being chosen for practice and the third one was the part that is not yet productivity which are public health system to have readiness by focusing on the service via primary network.

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Problems in service providing at Primary Care Unit are as follows:

Somchart Torugsa (2003: 82) mentioned that for each problem to be more or less important, it must be considered from the result of the problems that may arise out of these issues as follows:

1. The person such as service user, implementer and department administrator.
2. The department that provides the service.
3. The community which the office is located.
4. The entire country.

To consider everything in the long term, adverse affect to life and asset of the people, is important at all the time. Especially, when the problems are in line with the high level policy and are demanded by the people. Since we have limited resources and time, all problems many not be solved at the same time. Problems need to be prioritized.

Public Health Research Institute (2004: 1-3) conducted an operational research in the Primary Health Service System in the second stage in the pilot area of 4 regions. The results indicated that people were not confident in the quality of the primary service.

Suppattra Sriwanichchakorn (2004: 28) mentioned that the nurses who rotated to provide the service at the health center lacked the spirit of ownership of the primary service center, while the health center officers were confused in the roles and some were not satisfied with the implementation of the hospital which was different from the concept and nature of the health service implementation.

Srikullaya Wutthinanchai (2002: 102) studied the implementation system of the primary service unit under the Comprehensive Health Assurance at Pijit hospital and service network in Pijit. The study populations were the Primary Care Units at Pijit Hospital, Kakang Hospital and Sarklek Hospital. Data were from related documents, in-depth interview of service users from three service units. The results showed that assigning the staff of the hospitals to work at the Primary Care Unit without preparing the ability of the staff and no clear communication and coordination mate. Service providers at the health centers stressed because they thought that it was an additional job.

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Causes of the problems in providing the service of the Primary Care Unit

Somchart Torugsa (2003: 82) mentioned that the core of the problems in working is separated into 3 aspects due to the principle of :

1. Nature of the job itself that is troublesome in implementation, such as the job that is complicated that needs special tools, needs the person who has knowledge and have training which is hard to find such as: surgery job etc.

2. The resources that need to be used to do the job, it is not enough to do the job to get the expected job whether man, money, equipment or working system including the existing resources is not used in the work they need.

3. In the aspect of promotion and support, the obstacles are whether from working, politics, economic, society, laws, culture and traditions, etc.

Somchart Torugsa (1993: 4-7) mentioned that the causes of the problems in working as multifactor but the important causes in every working task has 2 factors as follows:

1. Working system that does not support each other whether in management administration, supporting system amd service development system which has relationship as follows:

Complicated working system and has a lot of steps that causes obstacles in working. The serious worker will get bored, tired and unwilling to work.

In all of the working systems, the biggest and most important process is the management system consisting of 7 activities which are: Planning, Organizing, Staffing Directing, Coordinating and Budgeting or POSDCORB. The one who is responsible for this implementation system is the top management of that depart

2. Behavior that does not support the work of responsible persons which are:

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2.1 Administrator's behavior such as: reluctant, indecisive, easily influenced, self-centered, talkative, not doing what they say, do not give moral support, decrease willingness, escape from problems, save one's own skin etc.

2.2 Implementer's behavior such as: no responsibility in the job, avoiding the job, ignore the job, fighting, using the benefits to blame colleagues, obsequiousness, acting in front of the administrators, etc.

2.3 Service user's behavior such as: easily influenced, exaggerated acting, using power, do not follow the rules, etc.

In the behavior that does not support the work, administrator's behavior is the most important factor.

Public Health System Research Institute (2004: 1-3) did an operational research for the Primary Health System Reform in the pilot area of 4 regions and found that:

In the aspect of service provider, they were not in one place and primary implementer could not reach the community. It ended up that there was a health center close to home but not close to the heart.

In the aspect of Comprehensive Health Assurance policy, there were regulations established in terms of structure, number of staff and service management of the primary service department that was different from the previous area that caused the health service in the primary level to be unable to adjust itself.

In the aspects of resources such as money and manpower, it was not sufficient.

Public Health System Research Institute (2004: 1-3) mentioned that the mission of the health service in the primary level still had obstacles from the people's health problems including the health service characteristics that can change according to the society, which is caused by:

Service Users: From the related research about the behavior of health care of the people, it was found that most of the people see the doctor when they are seriously ill rather than when the symptoms start or when they go for the annual physical check-up, they still buy medicine to heal themselves. Moreover, they

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found the health service problems in reaching some groups of people especially the laborers who move to other places but do change the house registration because it is inconvenient to go back to get the nursing treatment at the address in their house registration.

Service providers found that they have problems in their job, insufficient budget and number of staff and the budget is distributed for the nursing treatment rather than for disease prevention or health promotion.

Supattra Sriwannichchakorn (2004: 26-29) mentioned that the Comprehensive Health Assurance system implementation uses the management structure and previous service of the Ministry of Public Health as the principle. It needs to adjust the roles to support the implementation and there is no new organization setting except in setting up a group to do the special case whether to distribute the information, explain policy, follow up, assessment or training to explain to the responsible persons by using the existing experience and knowledge to be the base of working. There is no opportunity to test the implementation methods or test the feasibility of the standards because of the rush of the space expansion for the nationwide implementation in a short time. In this part, it may result in panic and confusion about the policy and implementation methods on the Primary Care Unit that is established in the Comprehensive Health Assurance system. Moreover, they have to adjust themselves to the new budget setting.

With the limitation that they have to rush, staff training can only explain the policy, standard of implementation and the primary implementation concept and the concept of primary implementation but staff may not understand the concept and the principle that the responsible persons have to understand clearly. Moreover, most of the administrators are too busy with the financial management rather than developing skills and ability of the staff in order to provide good service.

The result of the implementation varied due to the condition of interest and understanding of the nursing administrators of the healh center. Public health staff did not distribute equally, the staff health is less than the Urban Area but the standard was based on the same standard. It affects the implementer and

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administrator who are responsible with this matter. They cannot implement on the same standard including the conflict of implementation in many zones.

System of follow up, assessment, supporting and development to the Primary Service Unit follows the previous government system structure. It was found that there were some limitations because some of these people did not understand the concepts and principles of the primary service principle and had no experience in implementing the job development. They have also been familiar with the activity commanded that is similar nationwide and easy to follow up. Then the definition interpretation in the concept and principle of primary service system is the concept that they can practice easily such as: doctor setting team with the team from the hospital to implement at the health center.

Moreover, policy and concepts in primary service setting concept had been adjusted in the second and third year of the implementation, that caused each health center to adjust the implementation process every year, which caused more confusion and lack of confidence in the implementation.

Pussadee Sutthawej (2002: 104) studied the efficiency and productivity of the implementation of the primary service unit by the Comprehensive Health Assurance of the service network of Pattalung Hospital by using the questionnaire to collect data from medical staff and public health staff who worked in 7 Primary Service Unit in the Pattalung Hospital network. The results indicated that efficiency of the implementation in overall was in the medium level. In the input factor, it was discovered that the one that had the lowest point was “The different command line of the staff does not have any problem to the implementation and there is operation manual/ concept of the implementation”. In the aspect of implementation, it was found that the implementation was in the medium level and the lowest average point is “The compensation from the obligation in the primary service unit and human resources development plan was set clearly”. In the aspect of productivity in implementation, it was overall picture in the medium level. The one the had the lowest point was “Doctors had a role to develop the capacity of the health team and dentists had enough time to implement in the primary service unit to the needs of the people”. In the aspect of job by the standard, the one that had the lowest point was

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“The help in medical in the primary emergency level and ability of the people in order to take care of the health of the people in the big picture”.

Problems and obstacles about the implementation in the primary level was the concept of management was not clear, command line was different, and working was not united. Support in the equipment and tools that were necessary to the implementation from the Pattalung hospital was not enough and not clear. Number of the staff is less compared to the obligations and information system was not efficient.

Penkhae Larpying (2003: 116) analyzed the policy changes process to the setting and implementation of the Primary Care Unit in the province and sub district level in the pilot province in the first stage and second stage of the Comprehensive Health Assurance project by in-depth interview and discussing with the public health staff in the administrative and implementer level, community leaders and leader of the people in 4 provinces. The selection was so specific due to the format of finance and treasury management format that were used in the following province; Samutsakorn, Phuket, Sukhothai and Ubolrajthani. The results showed that the pattern of implementation of the Primary Care Units did not follow the concept of family medicine due to the limitation as a principle and lack of clear concept of the administrator of primary service contract network. In the field of the health promotion, disease prevention and control did not have a clear concept in implementation and had a flat budget to the network which in some parts did not have potential in implementation, government staff worried highly about the new budget system including salary and in the area that has more people, they had problems with manpower. Implementation of the Primary Care Unit is in a stage of adjustment in supporting the direction of the province and in according to following assessment rather than implementing according to the aims of people’s health care that will achieve the results. It is necessary to have reforms in manpower and structure system in management administration.

Ministry of Public Health (2003: 22,191) From the result of implementation according to the strategy planning of the Ministry of Public Health in

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the Economics and Society Development Plan Section 9 (2002-2006), it was found that problems and obstacles that affected reluctance in implementation were:

1. Budget distribution- The budget transfer to the unit was slow which led to being unable to follow the plan, which also made the implementation slow.

2. Human resources - There were limited resources, lack of understanding in policy and specific subject. There are frequent job rotation, officers had many job responsibilities and the job assignment was unclear due to the structure reform that resulted in lack of willingness, spirit and motivation in working.

3. Information and technology - There was no information and database to support the implementation. The manual was not adequate for the needs of the officers and public health volunteers. The records that needed to be filed in the Health Center and Primary Care Unit was a lot more and some parts are still missing and were not set up in the database because they did not have readiness to do the database and there were no computers and staff. Staff were not ready to do the information because they did not have expertise in hardware and software.

4. In the aspect of cooperation among government, private firm and people sector, it was not good enough since people did not understand their roles and realize some of the problems such as getting rid of the breeding place of mosquito larvae in the household, which is a major cause of Dengue. Also, some of the business owners wanted to gain profit and there was lack of cooperation from the public sector and other professions.

5. In the aspect of coordination and public relation; it is not strong enough in cases where cooperation and coordination from government, private and people sector was needed. Understanding and having public relations to increase understanding of the project implementation and the new policy are needed.

6. In the aspect of policy and implementation of policy, there was an urgent policy to respond to the administrators that had to be rushed to be finished by the due date, which caused the routine job that was set in the action plan to slow down.

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Thailand Development Research Institute Foundation (2004: 196-197), It can be concluded that the implementation in the first year of the 30 Baht Project, health center which were in the project had job obligations and high expenses because there were more people who used the service and the service use in the second half of the year had a higher rate than in the first half of the year. The revenues outside the 30 Baht Project had a decreasing trend in the second half of the fiscal year. Health centers got negative or had financial problems in the second half of the year which indicated that the budget for the health centers was not sufficient.

Amphol Jindawattana and Suranee Pipatrojjanakamol (2004: 76) stated that some of the staff lacked willingness in implementation become they had more obligations. The unclear regulations and frequent changes made the service users unable to confidently forecast the work in the future. At the same time, the doctors had more obligations by managing the finances of the health centers to be enough. It was a job that they were not good at. Moreover, they had to provide good service to the people either in rotating or treating the admitted patients. They might not have had enough experience in treatment and had high risk for them to get sued by the patients. If the transfer happened, the hospital would have more debts that caused the doctor to work with pressure and ready to get out of the government system.

Thailand Development Research Institute Foundation (2003: 186 - 189) did the research for the first year of the Comprehensive Health Assurance and found that the Public Health Provincial Office felt that the new budget made them lose their power. Then they tried to hold the budget from implementation which caused the distribution of the budget to be slow or to be different from the project objectives. Moreover, the new budget system that was established in the hospital also included the budget of the Health Center in their area of responsibility. In some of the hospitals who felt that they had financial problems, the hospitals who carried the budget would keep the budget for their own use and caused a lot of health centers not to have resources for their service. From the research, it was revealed that most of the health centers wanted to have freedom in financial management and were satisfied with the previous format of self-financial management. It was also observed that a

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lot of the big problems in PCU's arised from unclear command line (especially among the hospital officers who worked in PCU and existing health center officers). In many health centers, there was no regular doctor. Health station officers and nurses felt uncomfortable in the condition where the job was not clear and had some conflicts.

To separate the population and areas of the CUP in case that many health center were under 2-3 CUPs which is the problems that the responsible department was not clear that they should separate CUP by the ruling area or by other basis and how to solve the problems. Moreover, there were at least 3 problems with health center that is in private CUP. 1) the role of the establishment of the health center was to be a health promotion and disease prevention unit in the community and to be a Primary Care Unit, 2) to separate or combined budget of treatment and transfer and 3) to open the opportunity for the people to choose the health centers.

Problems of Primary Care Unit at Saraburi Hospital

The problems are similar to other places in which the results of implementation is not complete. There is a difference between expectation of the responsible person to the actual implementation, such as implementation result whether patient service, management or academic is not good as the patient, hospital administrators and officers who worked expected. It can be seen from the important indicators such as the rate of controllable of disease or illness, the admitted patient who is ill because of local chronic disease, participation in taking care of community health care. These problems are caused by:

1. Policy and Budget distribution

Lack of clarity in the level of policy and budget distribution such as the case of health promotion that does not specify the activities of the service that have to be provided in the community level. It caused confusion as to what budget they should use from the local level. Moreover, in the community, there is another group of people who used the other health benefits such as government benefits and social security. These two groups did not specify the benefits of the health promotion. These lead to no direction of health service establishment in the community level.

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2. Structure

There is lack of clarity of the organization structure because they are stuck with the previous structure.

3. Implementation staff

Since the primary service is a new system, human resources distribution can not distribute as planned because quantity of the existing staff in the system is limited and staff is combined with the hospital to provide secondary and tertiary service.

3.1 Network in health center development is necessary to add the manpower of the health center especially, the doctors and professional nurses to reach the standard of the Primary Care Unit. However, in reality it cannot distribute the manpower because manpower of the center hospital is not enough and does not in accordance with command line of the health center. Supporting the doctors and nurses to rotate in providing in Primary Care Unit cannot solve the problems in the long term because there are some staff who are against the secondary and tertiary service. This makes it hard to develop the service center.

3.2 Primary Care Units in the Urban Area. Even though there are Primary Care Units in the area of the hospital, they are responsible for a lot of people but the department which has responsibility is the medical department which does not have enough manpower. Because the new working system changes the method of working, it causes them to be unable to create the staff to support on time, Instead, they have to use manpower from other department of the organization. Officers who have knowledge, skills and attitude that are appropriate to provide the comprehensive health service is not enough with compared with the number of population. The staff has also other obligations aside from the primary job such as: doctors must have duties in the secondary service obligation, some of the nurses have duties in the tertiary level. Moreover, human resources do not have willingness because the government system reformed the policy that causes motivation in implementation. Short term implementation can be done by supporting the nursing manpower from the nursing department and doctor manpower from the other departments. The service should be set up in district and set the regular doctors and nurses to work in each area to regular provide service.

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To solve the problem in the long term, hospitals must have a recruitment plan for the doctors and nurses for the primary care system. It may affect the manpower in the secondary and tertiary service level, in which the expansion may be slow or stopped temporarily. Increasing manpower in the primary care services may also have the problems of the manpower development and lack of persons who are interested in the primary care, especially those who are medical field.

4. Service System Establishment

4.1 Service system establishment in the Primary Care Unit network for disease prevention promotion. Because it lacks of human resources, medication and medical equipment for diagnosis and treatment. Hospitals arrange for the doctor to rotate to go out for diagnosis in the primary stage, set up the supportive medication and medical equipment as needed. For the tools in diagnosis at the operation room, problems are solved by sending the ones they want to test to the hospital.

However, service system establishment in the Primary Care Unit network still is not ready to provide health service according to the standard.

4.2 Primary Care Unit in the Urban Area is the department in the hospital, therefore , they have readiness for treatment much more than network center but have no experience and of disease prevention in the community. City community has different lifestyle and culture. Conducting to survey again also caused the work in the community a lot of obstacles. Moreover, existing service system integrated the disease prevention into many health service such as ANC, WBC in the secondary and tertiary level that provides the general service to the service users. To take back all these kinds of responsibilities back to the Primary Care Unit, it cannot be done because of lack of manpower and familiarity from the service users. Now, for these jobs are ongoing development for comprehensive health service to the patient under the responsible area.

5. Potential and readiness of the human resources

Concept of service at Community Health Center is to provide the comprehensive service continuously to the service users , family and community. However, this concept was not cultivated among the human resources especially the doctors and nurses at the beginning. Human resources were trained as specialists in

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order to take care of those with diseases. Changing of the concept and building skill in the service is very difficult and even more difficult when the doctor still has to service as the specialist and rotate for primary service as well. Problem can be solve by having short term training either inside or outside the department. Long term problem can be solved by sending the staff to study and come back for this service.

6. Service users

The belief and trust of the people towards the Primary Care Unit is the problem in service because the service users believe in the health service of the large hospital more than the Primary Care Unit, although it is located in the city within the hospital area. Because people believe that treatment by the expert must be better than general doctor or primary care team. Therefore, the cross-line service using is happening to the secondary or tertiary, causing the health information of the Primary Care Unit to be discontinued and having a gap between the service users and service providers. Problems can be solved by doing the public relation at the beginning and improving the quality of the service of the Primary Care Unit

7. Participation of the community and local administrative organization

People do not realize the importance of health promotion due to the economic factors and no strong leader in the community. These cause the implementation for the disease prevention in the community to be very difficult and the implementation does not achieve its targets.

Furthermore, the Primary Care Unit and Local administrative organization who are responsible for building up the health and disease control in the area that can not be coordinated with full capacity. Due to the lack of joined planning, some activities are duplicated and some activities were argued whose responsibility is. This problems happen less in the outbound district compared to the Urban Area.

Solution for the problem of the service at the Primary Care Unit

Somchart Torugsa (2003: 82-83) mentioned that problem solving has to be done from its cause and every problem has a solution. Problem can be solved in many ways, the important aspects to solve the problems in working are

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human resources and working system. Increasing the resources are is difficult to be done in the real situation especially, in government department.

Supattra Sriwanichchakorn (2004: 41) mentioned that the primary service development solutions in the future are as follows:

1. The policy implementation process and main concept of the primary service development direction should be understood by all responsible staff as the main principle of the implementation.

2. Structure of health center and distribution of the staff including standard of human resources and the financial standard have to be developed.

3. Concept of health promotion and disease prevention should be clearly developed.

4. There should be an experiment and research to find the pattern of the various primary service management.

Public Health System Research Institute (2003: 1-3), based the research of primary health service pattern development in central region, has recommended the development of the Community based Public Health Center. Health Promotion and disease control was recommended by the local administrative organization that they should have participation in health development such as building the health park in the community, having activities against drugs and developing public utility service.

Primary Service Unit development

In the Urban Area,there is a primary service unit with a structure of small health center to provide comprehensive public health as front line care to the people. It is the health centers that people can register for their health service. Human resources have the ability to provide comprehensive according to societal condition and response to the various needs of the people. This health center can provide service to everyone because it is easily accessible. Nowadays, health center that has such kind of services are not enough and there are needs to increase this kind of health center. At present, private clinics have a few of health promotion services

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and disease prevention. It is necessary to promote the private unit to do these kind of jobs.

In the up country area, there are more Primary Care Units. In Thailand, health center are the health service sectors that provide comprehensive service in primary care. However, the capacity of the health center is not enough. It is necessary to increase capacity including the human resources development to have ability in providing treatment and taking care of the patient under the network of existing hospital.

Therefore, in conclusion, the intention of the standard establishment under the Comprehensive Health Assurance is to upgrade health centers to be Primary Care Units by increasing capacity of the health center in order to be able to provide the qualified primary service in quality. In the Urban Area there are no health center that have existing structure adjustment such as City Public Health Service Center, Private Clinic that can take care of the people's health comprehensively and continuously, The role of the hospital has to be adjusted the service unit for the patient required complicate treatment which was transferred from the Primary Care Unit.

Nisarat Hanwongsa, et al. (2004: 35) compared the development pattern of the team working of the health staff between experiment group and control group. Samples were 22 health staff in Primary Care Unit at Amphur Bahn Bueng, Chonburi. The results found that the team working of the control group before and after the experiment was not different overall and in each aspect, while the team working of the experiment group was higher than before the use of the team development. The comparison of the team working of the experiment after the use of development pattern was higher than the control group who work normally. Due to the control group has no development in working skill seriously and continuously, there was no development in knowledge and understand in team working. The problem that was always found was the collaboration in the health team. The urgency of the government lead to splitting job as everyone do their own, working climate is unresponsive to each other. Government policy and order that always change also causes confusion to the working and assigned mission.

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Mantana Prateeprasen, et al (1997: 181) conducted the in-depth interview with community health center in 42 health centers. Subject provided suggestions as follows:

1) The importance of the District Public Health Service Development is to develop the potential of the health station to be able to respond to the health problems of the people comprehensively to reduce the unnecessary cross-over service.

2) In an emergency case, the transfer system and information system for the management to beware of people's health status in the responsibility area of the health center should be developed.

3) The patient transfer system should be improved to be efficient rather than expanding service in treatment at the health center. Even though the doctor cannot provide full service due to the limitation in human resources and equipment, increasing staff capability and using the effective transferal system can be in implemented.

4) Information management system should be developed to have continuous report, patient follow-up and transfer, academic support and management including reporting the health situation and the cause of disease to the higher level, same level and lower level including to report to the district administrative organization.

Part 2: Literatures that are related to each variable

2.1 Service Quality

2.2 Expectation of the service user about service quality

2.3 Perception of service users about service quality

2.4 Related research

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2.1 Concept of Service quality and concept of service management that affects service quality and health service quality

Definition of service quality

Service quality comes from 2 words: quality and service. Quality means excellent and in line with the established standard in which the service provider have satisfaction to get the service (Stamatis, 1996: 6). Service means the result of action to the customer at the point of interaction to each other (Edvardson, 1993: 332) which is behavior from the service provider to the service users at that time.

Definition of Health Service Quality

For Health Service Quality, academic experts and health organization have given different definitions. The Joint Commission defines the meaning of health service quality as "quality is the degree to which care services increase the probability of desired patient outcomes and reduce the probability of undesired outcomes, given the current state of knowledge, Biggs (1996: 305) mentioned that service quality in health service means how to reach the standard of the profession or by the modern knowledge and ability of the service provider. Service quality in the health service means the try to respond to the expectation of the service users which is the achievement of the gaol to improve the service to satisfy the service users.

As mentioned, researcher concludes that Health Service Quality means the service the service that have characteristics which are in line with the standard appropriate without any error which affects the good output on the quality of life and respond to the satisfied needs of the health service users as shown in figure 4.

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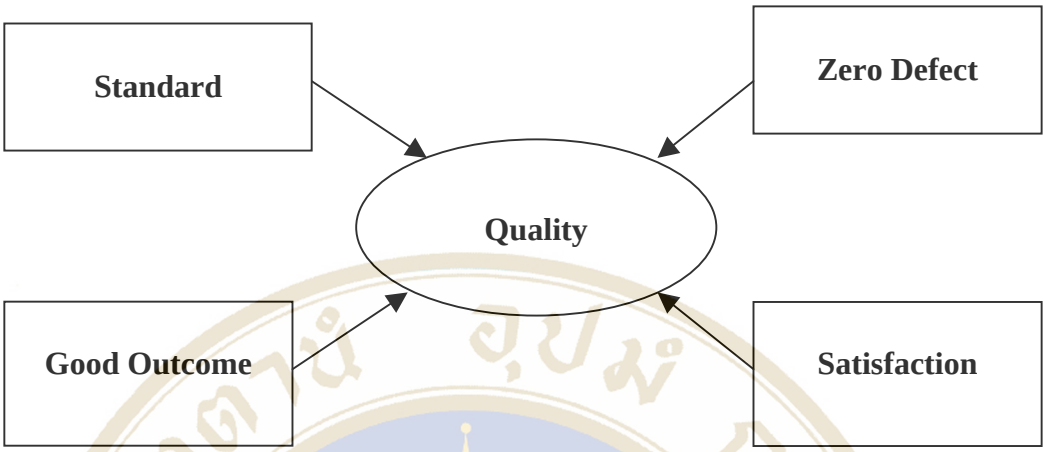

Figure 4 Conceptual framework for Service Quality in the healthcare system

Source: Suphachutikul, A. & Sriratanaban, J. (2000). ***Quality of the health care System***. Bangkok,Thailand: Dee. Sired: 5.

General Characteristics of Service and Health Service

General Characteristics of Service

In general, service is different for Goods in 4 aspects (Kotler, 2000: 431-432) which are:

Intangible service means the abstract service which cannot seen or known before the service are received such as medical service. The result will come out as performance, not products it cannot be touched or seen and cannot be measured or tested directly. It is difficult to assess and inspect quality. Therefore, service users must find the assurance for the patient to be confident and make a decision to get the service by having the principle to assess the aspects of services. Place must be able to build the confidence and convenience to the patients for example, the place must be wide, clean, designed to the convenience for the service users, have enough seats, good climate and waiting time for the service should not be long. (2) People must dress themselves appropriately, have good personality, bright, talk nicely to impress the patients and believe that they will get good service. Job of service provider should not be too many (3) equipment should be updated for fast service to satisfy service users (4) Communication materials, the media should be in line with the presented service characteristics of the service users. The communication

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should be efficient and fast. (5) Symbols or trademark that show service characteristics should be clear (6) Price setting should be appropriate to the level of service, clear and easy to classify the level of service.

The abstractness of the product or service may be different in each firm. Health service should be 25% abstract and 75% tangible. It is in fact behavior that the service provider practices with the service users (Markland, et al, 1998: 45)

1) Variability of Heterogeneity means service quality that may change when the service provider changes, change in the service users, time, place, environment that may cause consistency to be very difficult. What the service provider needs may not be the same with the clients because the perception or understanding is not in the same direction. Therefore, the quality control which can be done in 2 steps: to have training for the implementer to have human relationship, have skills providing in providing service and create the satisfaction to the service users by listening to the suggestions, recommendation and observing the information from the service users to improve for better service.

2) Inseparability means manufacturing, delivering and receiving the service that happens at the same time. Service users have a lot of participation in the service process. They have important roles in producing the qualified service and have to responsible with a lot of staff in the service department. At the same time the service characteristics have limitations because one service officer can serve only one customer. Each service provider has specific characteristics that nobody can replace. The strategy to solve this problems is to use the time strategies for the fast and more service or use the equipment and to set appropriate service to match demand and supply.

3) Perishability service means producing and delivery service happen at the same time. Then ,service cannot produce in advance it cannot be kept for delivery or distribute later like other products. If the need happens consistently, the service will not have many problems. If the need is not consistent, it may cause problems easily, for example, the service cannot produce on time or no one wants to use the service such as the OPD service cannot forecast the amount of the patients in advance etc. This kind of situation causes the efficient controlling of

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the service to be harder than product manufacturing. Moreover, service depends on the demand of the service user.

The general characteristics of the service can be considered as follows:

1) Intangible products 2) Various, diversified and cannot be measured to match any standard product 3) service job has to deliver immediately after production is done 4) service occurred completely when the service is provided and received at a time but it cannot be hoarded. 5) Service quality in general is measured from the satisfaction of the service users but some parts of the service can be measured by the established standards such as speed, number of the service users 6) service providing and using will happen when it is in the area called “Service Interface” which may have wide or narrow boundary up to the business owner who set it, or it is the characteristics of those services all the time.8) service users always use the skills or expertise on their own for the service 9) service cannot be produced in the big amount like a product. 10) service that needs decision making and awareness of the service users. 11) The organization that provides service has expenses and cost of the manpower that are higher than the other places 12) the service unit is always decentralized and distributed to the positions that are close to the service users 13) the productivity measurement of any services can be done in terms of mathematics with difficulty. 14) Service quality control will get in the part of controlling the service process. 15) Service price setting in each organization is difficult tobe the same. Therefore, service user always compares the price with satisfaction that affects the decision making to use that service.

Any service may not have complete specific characteristics but may have similar characteristics that are mentioned above (Weerapong Chalermjirarat, 1996: 41-42; Markland, et al, 1996: 49-54).

Health Service Characteristics

Health service may have 4 characteristics like general service, health service has characteristics of profession to use knowledge and ability of the service provider and the service is considered as the benefit that government has

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established for the people to have good nutrition and living for non profit (Murdick, et al, 1990: 7). As well, the service is necessary to have interaction between service providers and service users in the high level.

The process of service has to be concerned with participation of the patient in quality service system setting (Edvardsson, 1993: 332). Moreover, the service provision should be based on the implementation of the profession ability and the advanced practice. Academics and ability of the service provider is very important and is one of the factors that are used to assess the service quality.

Service Quality Measurement in the hospital

Concept of Service Quality Measurement in the hospital are as follows:

Service Quality Concept specifies that quality has 2 factors which are: 1) Technical Quality which focused on the morality of the service or the experience to do things. The importance of quality is to do something right at the appropriate time. The right implementation is up to the experience and intelligence of individuals, and 2) Interpersonal or function quality involves many factors such as: communication, reliability, concern, sympathy and sensitivity to the perception of the patient.

Service Quality Concept in the Systematic Theory

Systematic Theory consists of 3 majors factors which are input, process and output Donabediam mentioned that the consideration of the Health Service Quality should be done in the structure, process and outcome. Structure means exact characteristics of the hospital and organization service system such as amount and qualifications of the service provider, size, equipment, location of the hospital and other supporting items. It can be said that the characteristics of the organization and human resources as well as other factors in management such as command line structure, working environment lead to the service quality. Process is the implementation method by the established standard while outcome means the result from the implementation by focusing on the health condition of the patient. Later, Stiles and Shortell, 1994: 309-326) concluded the frame of quality assessment

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from the revised concept of Donabediam including structure, process and outcome in the horizontal and add on 3 more factors on the vertical which are: technical, interpersonal relation and convenience staff.

Moreover, Fitzsimmons and Fitzsimmons (1998: 280) presented service quality in health that it should be considered in the contents of the implementation whether in the structure, process, outcome which is presented in table 2.

Table 2 Concept of service quality measurement in Health service.

Consideration Guide	Details	Assessment Concept
1. Contents of implementation	Nursing implementation assessment.	Record of the implementation compared with the national or acceptable standard
2. Process	Activities in service and interaction to the service provider or service users details	Inspection of the unit implementation and patient interview.
3. Structure	Characteristics, physical materials of human resources and qualification of service provider.	Record the period of waiting time for the doctor and nurse for the service and the operation of the equipment.
4. Outcome	Changes of the health status of the patient due to the result of the treatment.	Morality rate as a result of treatment, satisfaction level of service and complaint from patient and complications of disease recorded in service.
5. Reflection	The appropriateness of treatment, reaching the service and impact on the community.	Number of patients who did not come for the treatment, distance to come for treatment and amount of service use.

Sources: Fitzsimmons, J. A. & Fitzsimmons, M.J. (1998). *Service Management: Operations, Strategy, and Information Technology*. Boston: Irwin McGraw–Hill: 280.

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Quality of service by the perception and expectation from service users

Service quality currently can be assessed from service user expectation which is more popular. The mentioned concepts focus on quality as responsive to the expectation and value of the service users. Health service quality assessment for the hospital should have 2 following aspects:

1) Quality of the performance that is in line with the implementation and standard means implementation by the established career standard.

2) Perceived quality means quality that can be considered by the service perception that can be accepted that it follows the expectation of the service users.

Quality by the consistency of implementation and standard and perceived quality will make the definition of quality in the hospital complete. The quality assessment by consistent implementation with one standard is not enough to assess the service quality of the hospital because it does not assess the opinion and the needs of the patient. The quality of supervision by the perception of the service user is not less important and it is very interesting because it focuses on the patient as a center. The mentioned concept has a level of significance that leads management to develop the organization quality (Anuwat Suppachutikul and Jirut Srirattanban, 2000: 1)

Concept of service quality by the perception of the service users and concept of the service management that affects service quality

Rationale of the service quality study

In general, the measurement of service quality has 2 patterns, which are: 1) measure the satisfaction of the service user only and 2) satisfaction measured by the perception and expectation of the service user. Mentioned concept was measured in service quality by the research group Parasuraman, Ziethmal and Berry who are academic experts, researchers and famous marketing experts from USA. The research had 3 stages from 1983 -1989. They received the research scholarship from the Marketing Science Institute (MSI) to find the answer about

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service quality. The principle of marketing states that the needs of the service user are important. This research uses the marketing concept to guide the study of the patient's service quality. Finally, they could produce the service quality dummy that can test the relation of the pattern in quantity or forecast, the service quality which combines the service quality measurement tools (Grapentine, 1999: 5)

The study was begun in 1983 when Parasuraman, et al. started to conduct the research to find the answer for the research problems which are: 1) "What is service quality?" 2) "What are the causes of service quality problems?" and 3) "How can the organization be able to solve the problems and how can it make service quality happen?" They did this through exploratory research about service quality. The time spent for the research was 7 years (1983-1989). The study was divided into 3 stages as follows:

First Stage: The research from 1983-1984 which was an exploratory research for developing the service quality concept. The result concluded the definition of service quality and related factors to the service quality assessment.

Second stage: The research from 1984 -1986 aimed to develop the service quality measurement and study the cause of service problems by studying the distinctive research which focused on the service user by using the pattern from stage one to improve and build the tools to measure the service quality called "Servqual" and improved it until the completed questionnaires were developed. The study in this stage concluded the standard to use for making a decision by comparing between the actual service perception and expectation of the

Third Stage: Implementation was from 1986 -1989 as the distinctive research in stage 2 but focused on the service provider that has many steps of implementation. The objectives were to study the gaps in the service and to find the cause of problems and service perception of the service users.

The result from 3 stages of research concluded that **service quality means how perception to the service responds to the needs of the service users by expectation,** or in other words, **service quality is the difference between expectation and actual service perception of the service users, that compares between the expectation before using the service and the actual service** (Teas, 1993: 18-34). It can be concluded into the equation as follows:

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Service Quality = Service Perception –Service Expectation.

If the perception has an equal value or more value than the expectation of the service user, there is satisfaction. If the perception is less than the expectation of the service user, dissatisfaction to the service will occur (Schmenner, 1995: 95).

Principles in service quality assessment that should be remembered are:

Service quality is a more difficult subject to assess than product quality.

Service quality is based on the result of perception of the service user to the service provider and process assessment that can be implemented when the service is finished.

Service quality perception is the result from comparison of expectation in service use and actual service perception level of the service user (Kurtz & Clow, 1998: 99).

Service Quality Measurement Dimension

Service Quality Measurement Dimension is considered from 5 factors as follows:

1) Tangibles of the service means physical characteristics of the facilities such as: place, human resources, equipment, communication documents and symbols including the environment that make the service user feel that they get concern and intention from the service provider. The service will be presented in terms of tangibles so the service will be perceived by the service user clearly.

2) Reliability means the ability that provider can provide service according to the contract that is given to the service user everytime that they use the service. It must be correct, appropriate and the result is the same in every place of service. The consistency will make service user feel that the service is trustworthy and credible.

3) Responsiveness to the service means the readiness and timeliness. Service user can get service easily and receive the convenience from the

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service and they must distribute the service comprehensively, quickly and with a short time for waiting.

4) Assurance to the service user means the ability to show the knowledge, skills, and ability to provide the service and respond to the needs of service users with politeness, soft, good manners in communication and making sure that service user will get the best service.

5) Empathy means ability to take care of the service user with the different needs and urgent necessities of each service user.

Service user can assess the service quality by comparing between expectation in service and perception in 5 mentioned aspects: Gap is the difference between expectation and perception is service quality measurement, mostly it is a positive or negative feeling. If the perception that happened has less value than expectation, it means the unacceptable happened.

In the service quality measurement, it was found that reliability had most importance 32%, next was responsiveness 22%, assurance was 19% empathy was 16% and tangibles was 11% (Ziethaml, et al. 1990: 28)

Factors that affect the expectation and perception in service quality

The results from the research reveald that the factors that affected the expectation of the service user was word of mouth communication, personal needs, past experience and external communication, as shown in figure 5.

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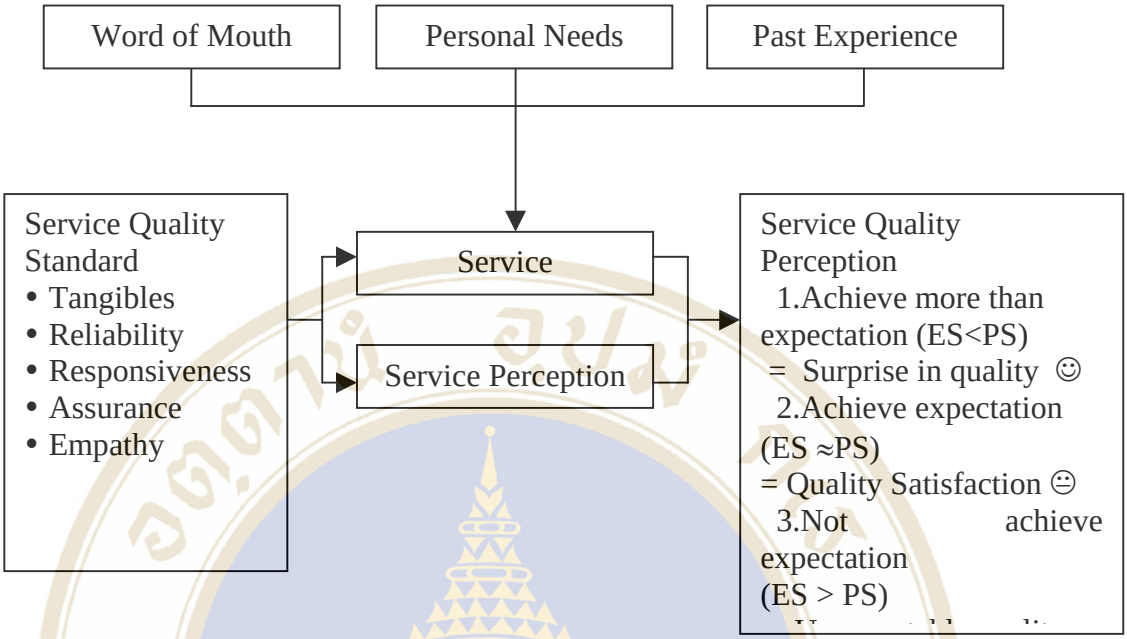

Figure 5 Perception on service quality

Sources: Fitzsimmons, J.A.& Fitzsimmons. (1998). *Service management: Operations, Strategy, information technology*. (2nd ed.) Boston: Irwin McGraw-Hill.: 270.

2.2 Expectation of Service Users to the Service Quality

Definition of Expectation

Definition of expectation has been mentioned differently and can be presented as follows:

Webster's Dictionary, 1988: 478) defined expectation as the forecast of the future in a good way, the expectation may be the forecast in the future in good or bad.

Oxford University's Dictionary, 1989: 281) mentioned the definition of expectation as the mental condition that may be conscious or intelligent opinion of the person who can forecast something in advance whether it should or should not happen.

The definition of expectation can be concluded as an intelligent idea of the person who can forecast something in advance whether it should or should not happem in the future by the necessity and appropriateness to the situation. The forecast is based upon the past experience of each person.

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Expectation in service is a mental condition, it is an intelligent idea and feeling of someone to something in advance (Oxford Universty, 1989: 281) and the person's expectation has 2 levels, which are Level 1 is the expectation of the service user which it should have or should be and Level 2 is the expectation of the service user in hope that they will get service like last time that causes the service user to accept it (Berry & Parasuraman, 1991: 58-59).

Therefore, service provider should know the level of expectation that will satisfy the service users (Stamatis, 1996: 159-160) to set service to respond to their expectation very well.

2.3 Perception of service users about service quality

Perception is the process wherein a person touches the external stimulus and translates the definition by using past experience. It is a tool that helps to translate that thing to be known and understood (Webster's Dictionary, 1985: 1002: Theppanom Muangman and Sawing Suwan, 1997: 6).

In the mentioned study, there was a tool development to measure the service quality by having the structure of service quality measurement called "SERVQUAL" which is a questionnaire that has 22 questions. The questionnaire has 2 parts: Part 1 measures the expectation of the service users and Part 2 measures the service perception. Each question has an estimate point in 7 levels starting from strongly disagree = 1 until strongly agree = 7. The calculation of service quality has 2 methods, which are:

Pattern 1: No weight point calculation of importance by finding the difference of the perception point and expectation point then finding the average point in each person.

Pattern 2: Calculate the weight point of importance by finding the average point of service quality without weighing the importance point in each aspect multiplied by importance point weight that service user assesses to the service quality in each aspect. This method provide details in measurement more than pattern 1.

Principles of Service Management that affect service quality

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The cause of implementation that resulted in no service quality is a gap that makes service not to follow the expectation of service user. The Service Quality Model summarizes service quality as creating the balance between expectation and perception of the service user by closing a total of 5 gaps in the part of service providers and service users as follows:

Gap 1 is the gap between the expectation of the service provider and perception of the administrator to the expectation of the service users.

Gap 2 is the gap between perception of administrator to the expectation of the service user and established characteristics or standards of service.

Gap 3 is the gap the between characteristics of the established service quality and service to the service user.

Gap 4 is the gap between the actual service and communication to the patient to know the acknowledgement service.

Gap 5 is the gap that happens due to the lack of correspondence between the expectation of the service user and service perception when the service used come for actual service.

Details of the gap are as follows:

For the service users to perceive the service quality, they have to reduce the gap or problems that happen from the gap.

Teas (1993: 18-34) mentioned that the perception in service of the service user is to assess the result of management that has the gap between expectation to the service of service users and perception in service. This gap is the important factor that lead to the development and improvement of quality service to reduce the gap.

Desarbo, et al. In Rust & Oliver, Eds., (1994: 203) mentioned that the service perception of the service user can be created as the pattern of the service quality by having the indicator of the 3 perceptions as follows:

1) The service that has quality by the important technique method of that service.

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2) Service user can perceive the interaction between service provider and service user. Therefore, the most important in service is to create the service image as being reliable to the service user.

3) Service quality perception is to assess the service from service user which is different from service expectation and service perception of the service result is achieved by expectation so it assesses whether the service has quality.

Therefore, the medical service quality assessment depends on the comparison of the quality of the expected service that they receive. Thus the quality of good service means to receive the service that is right or exceeds the needs of the service user. Service provider must understand the expectation and remember to keep the value of the service to have good quality and administrators should use it as an objective or major policy of the organization by creating the image of the hospital by focusing on the service quality that impresses the service user as a principle.

Factors that affect the perception of the service user

Researcher studied the characteristics of the service users which are the factors that affect the service quality such as: gender, age, marital status, education, monthly income, frequency of use and motivaton of service with the details as follows:

2.4 Related Research

International Research

Aday and Anderson (1975) studied the satisfaction of the people to the nursing service in the U.S. in 1970 and found that the topic that people are not satisfied the most was inconvenience in service and expenses in service. This is in line with Halka., et al. (1971) who studied the satisfaction of the low income people to the medical service in 1969 in North Carolina and found that low income people were not satisfied in terms of convenience and expenses in service. Later in 1971, Aday and Anderson pointed out the 6 fundamentals about satisfaction of service users to the nursing treatment and feelings from the service. For the medical service system, satisfaction in the following 6 aspects need to be developed:

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1. Satisfaction to the convenience which are:

1.1 Office waiting time.

1.2 Availability of care when needed

1.3 Accessibility of care.

2. Satisfaction to the service Coordination are:

2.1 Getting all needs met at one place where the patient can ask for every kind of service according to his/her needs.

2.2 Concern of doctor for overall health of the patient which are physical and mental.

2.3 Follow-up care.

3. Satisfaction to the interest of courtesy, such as friendly actions of the service provider and empathy to the patient.

4. Satisfaction to the medical information which can be divided into 2 types, which are:

4.1 Wrong information of illness.

4.2 Treatment information of the patient such as: self-practice, medication etc.

5. Satisfaction to the service quality such as overall patient care quality in the opinion of the service to the patient.

6. Satisfaction in the medication expenses.

7. Satisfaction to the interest in the patient such as showing the temperament.

Johnson & Lyth cited in Brown, et al., Eds., (1991: 181-182) mentioned that the expectation of the service user to the service should be predicted. This expectation comes from past experience and marketing management at that time. The service has to be communicated to the service user. If it is exaggerated from the actual service, it will make them disappointed. At least it will be hard to attract service users. Service users can assess the service quality by the satisfaction to the received service by dividing into 3 levels:

Level 1 Service user is unsatisfied: less quality

Level 1 Service user is satisfied: quality

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Level 1 Service user is impressd: high quality

Obesrt (1984: 2367-2375) studied measurement of service quality and satisfaction by the perception of the cancer patient. The results showed that convenience tools in service must consist of waiting time, telling to the patient and providing the convenience, enough care in appropriate accommodation and behavior in nursing communication.

Youssef, et al., (1996: 15-28) studied the health care in the hospital that had national health care service by using the service quality measurement (SERVQUAL) to assess the satisfaction of the service user compared between expectation of the patient before the treatment in the hospital and the perception of the patient after discharge which had 5 standards in assessment: 1) Tangibles 2) Reliability 3) Responsiveness 4) Assurance and 5) Empathy. It was noted that there was a significant negative difference.

Local Research

Patcharee Thongpare (1997: 74-82) studied service quality of the admitted patient at the Community Hospital in Area 2. The results indicated that service quality percieved by the admitted patient at the outstanding community hospital and general community hospital was in the same level which was unsatisfied. The comparison result of the average in the service perception in nursing service quality of admited patient of the general community hospital was higher than that of the outstanding community hospital in each aspect and overall at a significant level ($p < 0.05$).

Suangthip Wongphan (1998: 85-96) studied the service quality by company the expectation and perception of the service user in the admitted patient of the public hospital in Suphanburi. The results revealed that overall expectation and perception was in the high and medium with average point of 5.88 and 4.80 which was different at the level of significance ($p<0.01$) in overall and each aspect. Moreover, it was found that there was a difference in expectation at the level of significance ($p<0.05$) between service users who had different educational levels and

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frequency of use. Service users who had different gender, marital status, occupation, monthly income and motivation to use the service were not different in expectation about service quality. The service users who had different ages had difference in service quality perception or expectation at a significant level ($p<0.05$). Gender, marital status, occupational, momthly income and motivation to used the service did not show a difference at a significant level.

Sunee Chareonkul (2000: 73-82) studied the expectation of the people in Amphur Muang, Saraburi to the implementation of the Saraburi Regional Hospital in management, service and academic aspects. It was observed that the overall expectation in overall was in the medium level. People who lived outside the city had higher expectation than the people who lived in the city. Moreover, it was found that the distance from home to the hospital had a relation to the expectation of the implementation of the Saraburi Regional Hospital ($p<0.05$). Gender, age, marital status, occupation and people's income, health information received and service using experience had no relation to the expectation of the implementation at Saraburi Center Hospital.

Sanikarn Srimanee (2004: 69-74) studied the factors that are related to the satisfaction of the Primary Care Unit's service users which is located at the health center and Community Hospital as the major contractor. The results indicated that the level of overall satisfaction was at moderate level. Service coordination, temperament of the service provider, service quality and expenses was at high level. Moreover, it was found that gender, Primary Care Unit in terms of structure and processes, intention to the Primary Care Unit to the human resources and to the service has relationship with satisfaction of the Primary Care Unit. Gender, educational level, household income, health condition, traveling time, nursing treatment benefits and health information received had no relation to the satisfaction of the Community Health Center service user.

Vasinee Singsa (2004: 88-105) studied the factors that are related to the service perception to the Primary Care Unit of the service user at the OPD under the Comprehensive Health Assurance in Nonthaburi. It was found that the perception in service quality of the service user in overall and in each aspect was in the satisfied level. Perception level of the overall management administration was at

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moderate level. Moreover, it was found that gender, marital status, educational level, occupation, word of mouth, service using experience ($p < 0.001$) had a relation with service quality in Primary Care Unit. Gender, income, convenience of using service of service users had no relationship with the service quality perception in Primary Care treatment.

Piyarat Phanrangsee (2004: 41) studied the satsfaction of the people who had a Health Assurance Card of the hospital under the Medical Bureau in Bangkok. The results revealed that age, belief in the medical treatment ability and benefits perception of the Comprehensive Health Assurance card had positive relationship with the satisfaction in the service using at a significant level ($p < 0.01$). While educational level (lower than bachelor's degree) and size of the hospital (large size) had the relationship with the service satisfaction at $p<0.05$.

Iamduen Kaewsawang (2004: 98) compared the service expectation and the actual service received from the Comprehensive Health Assurance in Nonthaburi and examined the relationship between expectation and actual service received. The results showed that gender, age and education were the variables that affected the service quality assessment and most of patients had higher expectation than the actual service. Actual expectation and perception had a significant positive relationship to the service quality assessment. The expectation had a relationsip to the service quality assessment at a low level and actual service had a relationship with the service quality assessment at a somewhat high and very high level. When finding the difference between the expectation and actual service, it was observed that they had a negative or reverse relationship to the service quality assessment according to Obesrt's theory.

Supattra Liamwarangkul (1997: 89-93) studied the service quality at Sirindhron Rehabilitation Center of the service user. The results indicated that overall service quality was at good level and found that marital status, educational level, monthly income, occupation, type of physical equipment and frequency of use were different and affected the perception of the service quality at a significant level ($p<0.05$), while gender, current adrress and information sources of service users had no relationship with the service quality.

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Benjamas Sirikomolsathien (1999: 74-87) studied the satisfaction of the patient to the service in Somdej Phra Yupparaj Dejudom Hospital, Amphur Dejudom, Ubolrajjathani. It was found that service provider, service quality and service reach had a significant relationship with the service satisfaction ($p<0.05$). Age and income did not have a relationship with the service satisfaction ($p>0.05$). The sample group with different gender, occupation, marital status, educational level and type of the treatment nursing benefits card were not different in the level of satisfaction ($p>0.05$).

Lukkhana Sirirattanapholkul (2000: 98-107) studied the satisfaction of the service users under the Social Security System who come to the In-Patient Department. The results revealed that service users had satisfaction at a high level. The aspects that the wervice users satisfied the most were safety in the service and the least satisfaction was in physical convenience. Moreover, it was found that factors in service provision system and service provider including in Social Security Act and Workmen Compensation Fund had a positive relationship with the satisfaction at the level of significance ($p<0.05$). The experience in using the service and hospitalization had no relationship with the satisfaction ($p>0.05$).

According to the concept, theory and related research that are responsible with the service quality in the marketing concept found that every type of medical service should provide the importance and stick with the expectation as the standard in planning and implementation to make service setting respond to the needs and create satisfaction to the service users. When the quality of the service is assessed by the service user if the service can respond to the expectation and needs of the service user, it can be said that the service has quality. Service quality is based upon the comparison between expected service and perceived service. From the research, there were studies about the service businesses and it was found that the standard that established the service quality from service users consists of: Tangibility of the service, Reliability, Responsiveness to the service user, Assurance and Empathy to the service user. Therefore, researchers are interested in applying the service quality concept according to expectation and perception of the service users under the concept of Zeithaml, et al. (1990) by using the mentioned 5 service quality standards to assess the service quality of PCU.

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CHAPTER 3
MATERIAL AND METHODS

Research Design

This research is a cross-sectional descriptive study.

Population and Sample

Population is the people in Park Priew who are in the Urban Area, Amphur Muang, Saraburi with the total of 8,508 households. Saraburi Hospital can be divided into 5 service area subject were then selected by cluster random sampling.

Sample Size Calculation

Sample size was calculated by using the following formula (Vilai, 1985) (Reference in Tawatchai Worapongsatorn, 2000: 297)

$$\text{Formula : } n = \frac{Z^2_{\alpha/2}\ N\ \sigma_x^2}{Z^2_{\alpha/2}\ \sigma_x^2 + Nd^2}$$

$$= \frac{(1.96)^2(8,508)\ (0.42)^2}{(1.96)^2\ (0.42)^2 + (8,508)\ (0.05)^2}$$

which: n = Sample Size

N = Number of Households

Z = Standard value under the normal curve which has a value in line with the established level of significance.

σ_x = Standard Deviation of the variable X in the population = 0.42.

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d = Margin Error that is allowed in the total estimation which is set as 0.05.

Therefore, sample of 263 people in 263 households Park Priew Sub-district were selected.

In the calculation of the sample size to get the studied sample, researcher calculated the sample size of people in Park Priew Sub-district in the proportion as follows:

Table 3 Sample size of studied population in each zone

Zone	No. of Households	Sample size
1	2,800	87
2	2,078	64
3	550	17
4	1,527	47
5	1,553	48
Total	**8,508**	**263**

Research Instrument

A questionnaire that was developed based on the standard of the Community Health Center (Health Service System Development Office, Health Service Support Department, Ministry of Public Health) and the standard of OPD activities by using the assessment concept of Parasumaman, (1991: 437-438) which is divided into 3 sections as follows:

Section 1: General information of the respondent including gender, marital status, educational level, occupation, monthly household income, health care benefits, frequency of use, motivation to use the service, residence zone, traveling time from home to PCU, and health information received.

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Section 2: Service Quality that service user expected before using the service at the hospital and service the service user received after using the service which consists of:

1. Tangible questions: 1-5, 8, 11.
2. Reliability questions: 6, 13, 15, 17-18.
3. Responsiveness questions: 7, 9, 14, 20 – 22.
4. Assurance questions: 10, 12,16,19,29 – 30.
5. Empathy questions: 23-28.

Section 3: Problems, Obstacles, and Recommendations for the service.

Scoring

In Section 2, scores ranged from 1-7 as follows: (Parasumaman, 1991: 437 – 438)

7 = Strongly agree means the highest level of agreement that PCU should have the mentioned characteristics

6 = Agree means agree that PCU should have the mentioned characteristics

5 = Somewhat agree means quite agree that PCU should have the mentioned characteristics

4 = Uncertain opinion means not sure that PCU should have the mentioned characteristics

3 = Somewhat disagree means quite disagree that PCU should have the mentioned characteristics

2 = Disagree means disagree that PCU should have the mentioned characteristics

1 = Strongly disagree means the highest level of disagreement that PCU should have the mentioned characteristics.

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$$\text{Range of Measurement} = \frac{\text{Max Score} - \text{Min Score}}{\text{Number of class}}$$

$$= \frac{7 - 1}{3}$$

$$= 2$$

Therefore, average score can be classified into **3** levels as follows:

Average Score 1.00 – 3.00 means it is in **low level**

Average Score 3.01 -5.00 means it is in **moderate level**

Average Score 5.01 -7.00 means it is in **high level**

Testing Quality of the Instrument

1. **Content Validity:** Thesis committee and 3 experts were asked to inspect the validity and appropriateness of the content including, language used of the questionnaire. This revision was then made accordingly.

2. **Reliability:** Researcher tested the questionnaire with the sample group (n = 30) which has similar characteristics with the studied population in Dao Rueng Sub-District, Amphur Muang, Saraburi Province that used the service at Dao Rueng Primary Care Unit, total 30 persons. Data were analyzed to find the validity by using Cronbach Alpha Coefficient (Pimwan Silpasuwan, et al 1995: 133) Reliability value of expectation scale and perception scale were 0.97 and 0.93 respectively.

Data Collection

Researcher collected data in the following steps:

Data Preparation

1. Researcher submitted the letter from the Graduate School, Mahidol University to the Director of Saraburi Hospital, Saraburi Public Health provincial

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office and the Chief of Primary Care Unit, Dao Reung Sub-District to ask for the permission to test the questionnaire and permission to collect the data.

2. Researcher trained 7 research assistants on how to collect the data by explaining the standard of choosing the sample group and interview techniques in each questionnaire. Researcher collected the data with the research assistants at the beginning so that they could understand and be able to collect the data correctly, completely and perfectly.

Data Collection Implementation

1. Researcher and research assistants collected data by interviewing the people who are the sample group in each zone from March 1- 31, 2005.

2. Data were checked for completeness before being analyzed. If it is not complete, it has to re-interview.

Data Analysis

1. Descriptive Statistics

1.1 Frequency and percentage were used to describe the data in the characteristics of the service user which is nominal scale, in section of gender, marital status, occupation, health care benefits, motivation for using the service, residential zone. Education and health information received were ordinal scale data.

1.2 Average point and standard deviation were used to describe of the data in the characteristics of the service user which is ratio scale data in section of age, frequency of use and traveling time spent from home to PCU including describing the expectation of the service user about service quality and perception about the service quality which is ordinal scale.

2. Analytical Statistics

1.1 The differences of the average of expectation of service user about service quality and service user characteristics, age group, marital status, education level, occupation, average monthly household income, traveling time spent from home to PCU, residence zone (1-5), health information received, were tested by using

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One Way ANOVA and the differences in Multiple Comparison were tested by LSD. Used T statistics for service users with different gender and frequency of use.

1.2 The differences of the average in perception of service user about the service quality and characteristics of the service user who is in age group, marital status, education level, occupation, average monthly household income, traveling time spent from home to PCU, residence zone (1-5), health information received, were tested by using One Way ANOVA and the differences in Multiple Comparison were tested by LSD. Used T statistics for service users with different gender and frequency of use.

1.3 Differences between expectation and perception of the service user about the service quality were tested by using paired t –test.

Data Analysis Method

Create code operation

Bring the questionnaire to input the code.

Key the code into the computer and analyze data by computer program

Because of data collecting and developing questionnaire was limited, so motivation to use and health care benefit can not be the variables in this study.

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CHAPTER 4
RESULTS

The data from the interviews of 263 subjects living in 263 households in Park Priew Sub-district, Urban Area, Saraburi Province during 1-31 March 2005 were analyzed. The results of the data analysis are presented as follows:

Part 1. General data

1.1 Population characteristics of the people in Park Priew Sub-district.

1.2 Motivation to use the service

1.3 Frequency of service use

1.4 Reason for not using the service

1.5 Traveling time from home to PCU

1.6 Health information received

1.7 Experience in using the service

Part 2. Expectation and perception of people in Park Priew Sub-district about the service quality each aspect.

2.1 Expectation level of the people in Park Priew Sub-district who never used the service about service quality.

2.2 Expectation level of the people in Park Priew who used the service about service quality.

2.3 Perception of the people in Park Priew Sub-district about the service quality

2.4 The comparison of people's expectation on service quality in Park Priew between people who had used the service and those who never used.

2.5 Comparison between the expectation and perception of the people in Park Priew about service quality.

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Part 3. Comparison of the expectation and perception of the people in Park Priew Sub-district about service quality classified by the characteristics of the population, frequency of use, traveling time, and health information received and residential zone as follows:

3.1 Comparison analysis of the expectation of the people in Park Priew about service quality.

3.2 Comparison analysis of the perception of the people in Park Priew about service quality.

Part 4. Problems, obstacles and recommendations in the service of PCU.

Part 1. General data

1.1 Characteristics of the studied population in Park Priew Sub-district. (use and never use the service 263 households)

Table 4 Number and percentage of the people (use and never use the service) in Park Priew Sub-district classified by the characteristics (n=263)

Characteristics of the studied population	Number	%
1. Gender		
Male	74	28.1
Female	189	71.9
2. Age		
< = 30 Years	46	17.5
31 – 40 Years	42	16.0
41 – 50 Years	70	26.6
51 – 60 Years	46	17.5
60 Years and above	59	22.4
Mean = 47 years Standard deviation = 14.91 years		
Min = 16 years and Max = 76 years		

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Table 4 Number and percentage of the people (use and never use the service) in Park Priew Sub-district classified by the characteristics (n=263) (Cont.)

Characteristics of the studied population	Number	%
3. Marital Status		
Single	47	17.9
Married	190	72.2
Divorce, widow	26	9.9
4. Education		
No education	38	14.4
Primary School	69	26.2
Junior High School	28	10.7
Senior High School/ Primary Technical Certificate	53	20.2
Diploma/ Advance Technical Certificate	37	14.1
Bachelor's Degree and higher	38	14.4
5. Occupation		
Government officer/ State enterprise officer	29	11.0
Commercial/ Own business	87	33.1
Employee / Daily employee	54	20.5
Unemployed/Housewife/ Farmer	93	35.4
6. Household Income/month (baht)		
Less than 5,000	38	14.4
5,001 – 8,000	83	31.6
8,001 – 10,000	62	23.6
Higher than 10,000	80	30.4
7. Health Benefits		
Gold Card	182	69.2
Social Security	29	11.0
Reimbursement/Government officer/ State enterprise officer	44	16.7
Company Benefits	4	1.5
Life Insurance/ health insurance	4	1.5

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From the table

Gender: It shows that most of the people in the sample group are females 71.9%. and 28.1% are male

Age: Most of the sample group age between 41-50 years old (26.6%), followed by older than 60 years (22.4%). Mean age was 47 years old with the standard deviation of 14.91 years. The youngest was 16 years and the eldest was 76 years old.

Marital Status: Majority of the sample group are married 72.2%, followed by single 17.9%.

Education: Most of the sample group had education at primary school level (26.2%), followed by the senior high school/primary technical certificate level 20.2%.

Occupation: Most of the sample group were housewives/farmers/ unemployed (35.4%) and followed by the commercial / business owners 33.1%

Household income: Most of the sample group have household income/month between 5,001-8,000 baht (31.6%) and followed by those who have income higher than 10,000 baht (30.4%).

Health benefits: Most of the sample group used the Gold Card (69.2%) and followed by those who use the reimbursement benefits/Government Officer/State Enterprise Officer (16.7%).

Table 5 Number and percentage of the people in Park Priew Sub-district classified by the motivation to use the service (n=366).

Motivation to use the service	Number	%
From word of mouth	9	3.42
Due to own needs	38	14.45
Advertising /PR	4	1.52
Close to home	126	47.91
Convenient for traveling	77	29.28
Has chronic disease	89	33.84
Others	23	8.74

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This table reveals that majority of the motivation to use the service was that the PCU is close to the home 47.91 % and followed by having a chronic disease 33.84 %.

Table 6 Number and percentage of the people of Park Priew Sub-district classified by frequency of use at the PCU. (n=263)

Frequency of service use	Number	%
Never used the service	88	33.46
1-10 times	40	15.21
More than 10 times	135	51.33

From Table 6, it is shown that most of the sample group came for the service for more than 10 times 51.33% followed by those who used the service 1-10 times (15.21%)

Table 7 Number and percentage of the people in Park Priew Sub-district classified by the reason for not using the service at the PCU (n=263)

Reasons for not using	Number	%
Use treatment benefits at other places	9	3.42
Seek treatment at clinic/ hospital	7	2.66
Believe in the specialist	3	1.14
Have chronic disease under special doctor care	3	1.14
Not sure in the treatment outcome of the PCU whether it is different from OPD or not	3	1.14
Slow Service	3	1.14
Cannot get the service during office hours	2	0.76
Healthy / No comments	233	88.59

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From Table 7, 30 people who have comments from 263 persons (11.41%) stated the reason that they never used the service at the Primary Care Unit, Urban Area, Saraburi Hospital that they had to reserve their really benefits at other places (3.42%), followed by the reasons that they regularly seek treatment at clinics/hospitals 2.66%.

Table 8 Number and percentage of the people in Park Priew Sub-district classified by traveling to get the service at PCU (n=263)

Traveling time to get service at PCU (Minutes)	Number	%
1-10	67	25.0
11 – 20	70	26.7
21 – 30	86	32.8
> 30	39	14.9

From table 8, it is indicated that most of sample group spend time traveling to the PCU around 21-30 minutes (32.8%), followed by 11-20 minutes (26.7%) and 1-10 minutes (25.0%).

Table 9 Number and percentage of the people in Park Priew Sub-district classified by the health information received from the PCU. (n=263)

Health information received from PCU	Number	%
Never received	63	24.0
Once in a while	165	63.0
Often	33	12.6

From Table 9, Most of sample group received their health information from the Primary Care Unit once in a while (63.0%) and never received (24.0%)

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Part 2. Expectation and perception about service quality of the people in Park Priew Sub-district who never used the service

2.1 Expectation level of the people in Park Priew Sub-district who never used the service about service quality.

Table 10 Mean and standard deviation of the expectation score of service quality and the expectation level among of the people of Park Priew who never used the service at the PCU (n=88).

Expectation of Service Quality	Expectation score		Expectation level
	$\bar{X}$	SD	
1. Tangibles	6.77	0.46	High
2. Reliability	6.78	0.48	High
3. Responsiveness	6.79	0.41	High
4. Assurance	6.76	0.48	High
5. Empathy	6.72	0.68	High
Total	**6.77**	**0.44**	**High**

From Table 10, it can be noted that the sample group who never used the service have mean Expectation of Service quality, of 6.77 which was in a high level. When each aspects of service quality is considered, it shows that responsiveness has the highest mean at 6.79, followed by reliability at 6.78. The aspect with the lowest mean of the expectation about the service quality average is empathy with the mean of = 6.72 which was still in a high level.

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2.2 Expectation level of the people in Park Priew who used the service about service quality.

Table 11 Mean and standard deviation of the expectation score of service quality and the expectation level among of the people of Park Priew who have used the service at the PCU (n=175)

Expectation of service quality	Expectation score		Level of expectation
	$\bar{X}$	SD	
1. Tangibles	6.84	0.37	High
2. Reliability	6.85	0.42	High
3. Responsiveness	6.85	0.42	High
4. Assurance	6.86	0.39	High
5. Empathy	6.80	0.54	High
Total	**6.84**	**0.40**	**High**

From Table 11, it shows that sample group who have used the service have an average expectation about service quality of 6.84 which was at a high level. When each aspect of expectation about the service quality is considered, it can be noted that assurance has the highest mean point of 6.86, followed by reliability and responsiveness with the score of 6.85. The aspect of expectation about service quality that has the lowest mean was empathy = 6.80

2.3 Perception of the people in Park Priew Sub-district about the service quality

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Table 12 Mean and standard deviation of the perception score of service quality and the perception level among of the people of Park Priew who have used the service at the PCU (n =175)

Perception of service quality	Expectation score		Level of expectation
	$\bar{X}$	SD	
1. Tangibles	5.41	0.76	High
2. Reliability	5.53	0.73	High
3. Responsiveness	5.54	0.68	High
4. Assurance	5.48	0.74	High
5. Empathy	5.40	0.77	High
Total	**5.47**	**0.68**	**High**

From Table 12, it reveals that sample group in Park Priew Sub-district, Amphur Muang, Saraburi has mean in perception in service quality at the high level with the mean of 5.47. When perception of service quality is considered for each aspect, it can be found that every aspect had mean score at high level. The responsiveness had the highest mean of 5.54, followed by reliability which the mean of 5.53. The one with the lowest mean was empathy = 5.40.

2.4 The comparison of people's expectation on service quality in Park Priew between people who had used the service and those who never used.

Table 13 Comparison of the mean expectation score of overall service quality and each aspect by the experience in using the service

Expectation of service quality	Use the service		Never used the service		t	p-value
	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	6.77	0.46	6.84	0.37	-0.29	0.20
2. Reliability	6.78	0.48	6.85	0.42	1.11	0.27
3. Responsiveness	6.79	0.41	6.85	0.42	-1.02	0.31
4. Assurance	6.76	0.48	6.86	0.39	-1.75	0.08
5. Empathy	6.72	0.68	6.80	0.54	-1.09	0.28
Total	**6.77**	**0.44**	**6.84**	**0.40**	**-1.29**	**0.19**

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From table 13, it can be seen that expectation of the service quality among the sample group who used the service and the group who never used the service overall and each aspect were not different.

2.5 Comparison between the expectation and perception of the people in Park Priew about service quality.

Table 14 Comparison of the mean expectation and perception about the service quality of the Park Priew people in the Primary Care Unit in the Urban Area, Saraburi Province (n=173)

Service Quality	Expectation		Perception		t	p-value
	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	6.84	0.37	5.41	0.76	20.92	< 0.001
2. Reliability	6.85	0.42	5.53	0.73	19.91	< 0.001
3. Responsiveness	6.85	0.42	5.54	0.68	20.15	< 0.001
4. Assurance	6.86	0.39	5.48	0.74	20.83	< 0.001
5. Empathy	6.80	0.54	5.40	0.77	19.52	< 0.001
Total	**6.84**	**0.40**	**5.41**	**0.68**	**21.63**	**< 0.001**

From Table 14, it can be found that the expectation of the service quality overall and in each aspect of the people in Park Priew had higher mean than that of the perception at a significant level ($p<0.001$).

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Part 3. Comparison of the expectation and perception of the people in Park Priew Sub-district about the service quality classified by the characteristics, frequency of use, traveling time, health information received method, residence zone, and experience in using the service.

3.1 Comparison the expectation and perception overall and each aspect

Table 15 Comparison of the mean expectation score of overall service quality and each aspect classified by Gender.

Expectation of Service Quality	Male		Female		t	p-value
	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	6.87	0.31	6.83	0.39	0.61	0.55
2. Reliability	6.88	0.34	6.83	0.45	0.61	0.54
3. Responsiveness	6.84	0.39	6.85	0.43	-0.20	0.84
4. Assurance	6.85	0.34	6.86	0.40	-0.18	0.86
5. Empathy	6.78	0.35	6.80	0.54	-0.21	0.83
Total	**6.84**	**0.35**	**6.83**	**0.43**	**0.11**	**0.91**

From table 15, it can be noted that expectation about service quality overall and for each aspect for the sample group of male and female was not different.

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Table 16 Comparison of the mean expectation score of overall service quality and each aspect classified by age group.

Expectation of Service Quality	Age (Year)										F-ratio	p-value
	< 30		31 – 40		41 – 50		51 - 60		> 60			
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	6.73	0.57	6.94	0.23	6.83	0.31	6.84	0.36	6.85	0.36	1.01	0.41
2. Reliability	6.82	0.55	6.94	0.29	6.84	0.37	6.77	0.51	6.86	0.39	0.59	0.67
3. Responsiveness	6.76	0.70	6.94	0.31	6.86	0.32	6.78	0.45	6.88	0.36	0.79	0.54
4. Assurance	6.76	0.62	6.96	0.17	6.87	0.30	6.81	0.43	6.87	0.36	0.90	0.47
5. Empathy	6.71	0.76	6.90	0.48	6.84	0.39	6.62	0.78	6.86	0.36	1.48	0.21
Total	**6.75**	**0.63**	**6.94**	**0.29**	**6.85**	**0.32**	**6.77**	**0.47**	**6.86**	**0.35**	**2.89**	**0.47**

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From table 16, it can be noted that expectation of service quality overall and each aspect for the sample group was not different according to different ages.

Table 17 Comparison of the mean the expectation score of overall service quality and each aspect classified by Marital Status.

Expectation of Service Quality	Marital Status				t	P-value
	Single/Divorce/ Separate/Widow		Married			
	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	6.78	0.47	6.86	0.33	1.301	0.19
2. Reliability	6.84	0.43	6.85	0.42	0.017	0.99
3. Responsiveness	6.82	0.46	6.86	0.41	0.586	0.56
4. Assurance	6.84	0.37	6.86	0.39	0.309	0.76
5. Empathy	6.74	0.57	6.82	0.53	0.806	0.42
Total	**6.80**	**0.43**	**6.85**	**0.39**	**0.689**	**0.49**

From table 17, it can be noted that expectation about the service overall and for each aspect among the sample group with different marital status was not different.

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Table 18 Comparison of the mean expectation score of overall service quality and each aspect classified by Educational Level

Expectation of Service Quality	Educational Level												F-ratio	P-value
	No Education		Elementary School		Junior High School		Senior High School/ Primary Tech Cert		Associate degree/ Adv Tech Certificate		Bachelor's Degree and higher			
	$\overline{X}$	SD	$\overline{X}$	SD	$\overline{X}$	SD	$\overline{X}$	SD	$\overline{X}$	SD	$\overline{X}$	SD		
1. Tangibles	6.59	0.52	6.88	0.38	6.89	0.29	6.89	0.26	6.82	0.39	6.91	0.21	2.83	0.02
2. Reliability	6.48	0.61	6.88	0.47	6.90	0.31	6.90	0.29	6.92	0.20	6.98	0.17	4.78	<0.01
3. Responsiveness	6.59	0.52	6.86	0.49	6.88	0.40	6.90	0.32	6.87	0.37	7.00	0.00	2.61	0.03
4. Assurance	6.56	0.54	6.88	0.42	6.91	0.39	6.91	0.22	6.89	0.31	6.91	0.12	3.59	<0.01
5. Empathy	6.47	0.69	6.79	0.67	6.89	0.47	6.86	0.38	6.87	0.37	6.94	0.23	2.26	0.05
Total	**6.54**	**0.53**	**6.86**	**0.47**	**6.89**	**0.36**	**6.89**	**0.28**	**6.87**	**0.33**	**6.95**	**0.13**	**3.32**	**<0.01**

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FromTable18, comparison of the mean difference of expectation overall and for each aspect between 6 education groups found to be different at a significant level ($p<0.05$) except empathy. The difference was found between: the no education group and higher education group. Therefore, expectation about service quality is significantly different according to educational level.

Table 19 Comparison of the mean expectation score of overall service quality and each aspect classified by occupation

Expectation of Service Quality	Occupation								F-ratio	P-value
	Government/ State Enterprise officer		Commercial/ Business Owner		Private employee/ Daily employee		Unemployed/ Housewife			
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	6.82	0.36	6.90	0.28	6.77	0.37	6.82	0.44	1.05	0.37
2. Reliability	6.81	0.54	6.91	0.30	6.82	0.39	6.81	0.49	0.62	0.60
3. Responsiveness	6.85	0.42	6.89	0.34	6.79	0.42	6.83	0.49	0.48	0.69
4. Assurance	6.88	0.27	6.90	0.34	6.84	0.30	6.81	0.47	0.63	0.59
5. Empathy	6.78	0.59	6.86	0.47	6.72	0.62	6.78	0.56	0.50	0.68
Total	**6.83**	**0.42**	**6.89**	**0.32**	**6.79**	**0.38**	**6.81**	**0.48**	**0.64**	**0.59**

From table 19, it is indicated that expectation about service quality overall and each aspect of the people in the sample group who have different occupations is not different.

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Table 20 Comparison of the mean of expectation score of overall service quality and each aspect classified by monthly household income.

Expectation of Service Quality	Monthly Household income								F-ratio	P-value
	< 5,000		5,001 – 8,000		8,001 – 10,000		> 10,000			
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	6.78	0.39	6.87	0.36	6.89	0.37	6.77	0.38	0.20	0.31
2. Reliability	6.76	0.46	6.92	0.29	6.87	0.48	6.77	0.48	1.47	0.22
3. Responsiveness	6.72	0.46	6.89	0.36	6.88	0.49	6.82	0.40	1.12	0.34
4. Assurance	6.77	0.38	6.91	0.30	6.87	0.49	6.81	0.37	1.07	0.36
5. Empathy	6.65	0.69	6.89	0.34	6.81	0.67	6.74	0.53	1.39	0.25
Total	**6.73**	**0.43**	**6.89**	**0.32**	**6.87**	**0.48**	**6.78**	**0.41**	1.28	**0.28**

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From table 20, it can be noted that expectation about service quality overall and each aspect of the sample group with different monthly household income is not different.

Table 21 Comparison of the mean expectation score of overall service quality and each aspect classified by frequency of use

Expectation of Service Quality	Frequency of use				F-ratio	P-value
	1 – 10		> 10			
	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	6.89	0.37	6.82	0.37	1.12	0.26
2. Reliability	6.88	0.48	6.84	0.41	0.49	0.62
3. Responsiveness	6.86	0.53	6.85	0.39	0.12	0.90
4. Assurance	6.86	0.49	6.86	0.35	0.06	0.95
5. Empathy	6.79	0.65	6.79	0.51	-0.02	0.98
Total	**6.86**	**0.49**	**6.83**	**0.38**	**0.36**	**0.72**

From table 21, it was found that although sample group has different frequency of use, their expectation in overall and each aspect service quality was not different.

Table 22 Comparison of the mean expectation score of overall service quality and each aspect classified by Traveling time from home to hospital.

Expectation of Service Quality	Traveling Time						F-ratio	P-value
	1 – 10 Minutes		11-20 Minutes		21-30 Minutes			
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	6.69	0.53	6.85	0.29	6.90	0.28	4.83	<0.01
2. Reliability	6.69	0.61	6.87	0.33	6.92	0.31	4.23	0.02
3. Responsiveness	6.68	0.65	6.86	0.31	6.93	0.29	4.56	0.01
4. Assurance	6.68	0.59	6.87	0.29	6.94	0.23	6.72	<0.01
5. Empathy	6.65	0.87	6.79	0.43	6.93	0.30	6.62	<0.01
Total	**6.66**	**0.62**	**6.85**	**0.30**	**6.92**	**0.27**	**6.05**	**<0.01**

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From Table 22, comparing the difference of mean expectation of the people in 3 groups of traveling time reveal that there were different in is aspect or overall at a significant level ($p<0.05$). The differences were found between those who spend time in traveling 1-10 minutes, 11-20 minutes and 21-30 minutes, respectively. Therefore, the expectation of service quality is different in the aspect of traveling time from home to hospital. The group that spends longer time in traveling has a higher expectation than the one that spends less time in traveling.

Table 23 Comparison of the mean expectation score of overall service quality and each aspect classified by health information received

Expectation of Service Quality	Health information received						F-ratio	P-value
	Never		Once in a while		Often			
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	6.93	0.19	6.84	0.37	6.74	0.46	1.65	0.19
2. Reliability	6.94	0.29	6.86	0.39	6.69	0.56	2.77	0.07
3. Responsiveness	6.96	0.21	6.86	0.41	6.69	0.54	2.70	0.07
4. Assurance	6.94	0.24	6.87	0.38	6.74	0.48	1.97	0.14
5. Empathy	6.96	0.21	6.84	0.48	6.50	0.84	5.88	<0.01
Total	**6.94**	**0.22**	**6.85**	**0.39**	**6.68**	**0.54**	**3.25**	**0.04**

From Table 23, comparison of the difference of mean in expectation of the people in 3 groups shows that they are significantly different ($p<0.05$) whether in each aspect and overall except Tangibles, Reliability, Responsiveness and Assurance To find the different pairs by LSD, the different groups are those who never get any health information, those who got once in a while, and those who got it often, respectively There was also a difference in those who got once in a while and those who got it. Therefore, expectation of service quality was different according to health information received from the hospital. The group that received health information often has less expectation than the one that never receives and the once in a while group.

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Table 24 Comparison of the mean expectation score of overall service quality and each aspect classified by residential zone of Park Priew Sub-District

Expectation of Service Quality	Residential Zone										F-ratio	P-value
	Zone 1		Zone 2		Zone 3		Zone 4		Zone 5			
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	6.94	0.20	6.78	0.42	6.94	0.12	6.46	0.65	6.92	0.23	9.19	<0.01
2. Reliability	6.95	0.25	6.78	0.47	7.00	0.00	6.41	0.74	6.93	0.23	9.36	<0.01
3. Responsiveness	6.95	0.26	6.79	0.44	7.00	0.00	6.42	0.78	6.93	0.20	9.05	<0.01
4. Assurance	6.92	0.30	6.82	0.37	6.99	4.30	6.50	0.69	6.94	0.19	7.09	<0.01
5. Empathy	6.89	0.43	6.72	0.63	7.00	0.00	6.27	0.86	6.94	0.23	8.51	<0.01
Total	**6.93**	**0.26**	**6.78**	**0.44**	**6.98**	**0.05**	**6.41**	**0.70**	**6.93**	**0.19**	**9.71**	**<0.01**

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From Table 24, when the difference of mean expectation of 5 groups was compared, it can be found that there is a significant difference ($p<0.05$). The differences were found between those resided in Zone 4 and other zones. Therefore, the expectation of service quality was different according to the residential zone. The people in zone 4 had the lowest expectation in service quality compared to other zones.

3.2 Comparison of perceived service quality in each aspect and overall classified by the characteristics of the service users, frequency of use, traveling time, health information received and residential zone.

Table 25 Comparison of the mean perception score of overall service quality and each aspect classified by Gender

Perception of Service Quality	Gender				t	P-value
	Male		Female			
	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	5.36	0.86	5.43	0.73	-0.55	0.58
2. Reliability	5.42	0.93	5.57	0.64	-1.15	0.25
3. Responsiveness	5.43	0.76	5.59	0.64	-1.38	0.17
4. Assurance	5.37	0.89	5.53	0.67	-1.31	0.19
5. Empathy	5.32	0.82	5.43	0.75	-0.84	0.40
Total	**5.38**	**0.79**	**5.51**	**0.63**	**-1.12**	**0.27**

From Table 25, comparison of the difference of mean reveals that there was not significant different ($p>0.05$). Therefore, perception of the service quality was not different between males and females.

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Table 26 Comparison of the mean perception score of overall service quality and each aspect classified by Age.

Perception of Service Quality	Age (Year)										F-ratio	P-value
	< 30		31 – 40		41 – 50		51 – 60		> 60			
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD		
6. Tangibles	5.71	0.15	5.43	0.21	5.41	0.64	5.38	0.78	5.53	0.11	0.84	0.49
7. Reliability	5.22	0.22	5.53	0.19	5.43	0.52	5.54	0.69	5.75	0.64	2.32	0.59
8. Responsiveness	5.21	0.17	5.64	0.17	5.48	0.59	5.55	0.69	5.68	0.62	2.02	0.95
9. Assurance	5.08	0.22	5.67	0.18	5.43	0.56	5.46	0.75	5.63	0.60	4.62	0.04
10. Empathy	5.08	0.20	5.59	0.19	5.34	0.66	5.32	0.70	5.55	0.10	2.90	0.11
Total	**5.15**	**0.18**	**5.57**	**0.18**	**5.42**	**0.53**	**5.45**	**0.64**	**5.62**	**0.63**	**2.09**	**0.08**

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From Table 26, comparison of the difference of mean perception in service overall and each aspect of the sample group by different ages, there was not significant difference (p>0.05), except Assurance. Therefore, sample group's perception of the service quality was not different according to different ages.

Table 27 Comparison of the mean of perception score of overall service quality and each aspect classified by martial status

Perception of Service Quality	Martial Status				t	P-value
	Single/Divorce/ Widow		Married			
	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	5.42	0.84	5.41	0.74	0.12	0.91
2. Reliability	5.65	0.73	5.48	0.73	1.33	0.19
3. Responsiveness	5.59	0.73	5.52	0.66	0.61	0.55
4. Assurance	5.53	0.79	5.46	0.72	0.57	0.57
5. Empathy	5.44	0.87	5.38	0.73	0.48	0.63
Total	**5.34**	**0.74**	**5.45**	**0.65**	**0.66**	**0.51**

From Table 27, when the difference of mean perception of service overall and in each aspect was compared among, sample group with different marital status, there was not significant difference (p>0.05). Therefore, people in the sample group who had different in marital status were not different in the perception of service quality.

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Table 28 Comparison of the mean perception score of overall service quality and each aspect classified by Education

Perception of Service Quality	Educational Level												F-ratio	P-value
	No education		Elementary School		Junior High School		Senior High School/Primary Technical Certificate		Associate Degree/ Advance Technical Certificate		Bachelor's degree and higher			
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	6.01	0.73	5.31	0.74	5.37	0.55	5.44	0.85	5.05	0.68	5.29	0.63	4.32	<0.01
2. Reliability	5.73	1.02	5.53	0.69	5.51	0.65	5.60	0.75	5.33	0.54	5.36	0.64	0.87	0.50
3. Responsiveness	5.93	0.77	5.52	0.63	5.47	0.57	5.57	0.74	5.37	0.53	5.28	0.67	2.51	0.03
4. Assurance	5.82	1.02	5.46	0.66	5.34	0.50	5.53	0.79	5.29	0.61	5.33	0.67	1.56	0.18
5. Empathy	5.81	0.92	5.36	0.73	5.32	0.53	5.37	0.83	5.26	0.67	5.26	0.78	1.61	0.16
Total	**5.87**	**0.80**	**5.43**	**0.62**	**5.40**	**0.46**	**5.49**	**0.75**	**5.25**	**0.57**	**5.30**	**0.62**	**2.46**	**0.04**

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From Table 28, Comparison of the difference of mean perception overall and in each aspect of service quality between sample group with different levels of education, shows that there was a significant difference ($p<0.05$) overall, and in tangibles and responsiveness aspect. The differences were found between no education and higher education group. Therefore, the sample group that has a different level of education has a different expectation in service quality.

Table 29 Comparison of the mean perception score of overall service quality and each aspect classified by occupation

Perception of Service Quality	Occupation								F-ratio	P-value
	Government Officer/ State Enterprise officer		Commercial/ Business owner		Private employee/ daily employee		Unemploy/ housewife			
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	5.50	0.83	5.29	0.69	5.54	0.89	5.43	0.74	0.95	0.42
2. Reliability	5.48	0.81	5.45	0.69	5.57	0.96	5.59	0.62	0.41	0.75
3. Responsiveness	5.48	0.78	5.44	0.65	5.59	0.75	5.61	0.65	0.70	0.55
4. Assurance	5.49	0.75	5.34	0.61	5.52	0.97	5.57	0.70	1.00	0.39
5. Empathy	5.36	0.90	5.28	0.68	5.45	0.85	5.47	0.77	0.63	0.59
Total	**5.46**	**0.77**	**5.35**	**0.59**	**5.53**	**0.83**	**5.53**	**0.64**	**0.81**	**0.49**

From Table 29, it was found that when comparing the mean perception of service quality overall and in each aspect among sample group with different occupations, was not different ($p>0.05$). Therefore, perception about service quality among sample group with different occupations was not different.

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Table 30 Comparison of the mean perception score of overall service quality and each aspect classified by monthly household income

Perception of service Quality	Monthly Household Income								F-ratio	P-value
	< 5,000		5,001–8,000		8,001–10,000		> 10,000			
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	5.82	0.17	5.19	0.64	5.37	0.69	5.51	0.84	4.41	0.01
2. Reliability	5.77	0.15	5.40	0.66	5.62	0.57	5.47	0.93	1.81	0.15
3. Responsiveness	5.81	0.15	5.39	0.57	5.56	0.59	5.54	0.82	2.19	0.09
4. Assurance	5.73	0.15	5.32	0.58	5.52	0.66	5.51	0.93	1.88	0.14
5. Empathy	5.64	0.16	5.25	0.61	5.39	0.77	5.44	0.89	1.49	0.22
Total	**5.76**	**0.15**	**5.30**	**0.54**	**5.49**	**0.59**	**5.49**	**0.83**	**2.74**	**0.05**

From Table 30, it is indicated that when the mean perception of service quality overall and in each aspect of sample group who had different household income was compared, it showed no difference in perceived service quality among those with different income (p = 0.05), except Tangibles. Therefore, perception about service quality for the sample group did not differ by the household income.

Table 31 Comparison of the mean perception score of overall service quality and in each aspect classified by frequency of use

Perception of Service Quality	Frequency of use				t	P-value
	1 – 10		> 10			
	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	5.49	0.85	5.39	0.74	0.66	0.51
2. Reliability	5.49	1.02	5.54	0.64	-0.34	0.73
3. Responsiveness	5.54	0.89	5.54	0.62	0.05	0.96
4. Assurance	5.48	1.04	5.48	0.64	-0.03	0.98
5. Empathy	5.42	1.01	5.39	0.69	0.21	0.84
Total	**5.48**	**0.90**	**5.46**	**0.60**	**0.14**	**0.89**

From Table 31, it shows that there was not difference in mean perception of service quality overall and in each aspect between the sample group

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with different frequency of service use (p>0.05). Therefore, perceived service quality for the sample group was not different by different frequency of service use.

Table 32 Comparison of mean perception score of overall service quality and in each aspect classified by traveling time form home to PCU.

Perception of Service Quality	Traveling Time (minutes)						F-ratio	P-value
	1 – 10		11-20		21-30			
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	5.68	0.79	5.66	0.76	5.13	0.66	10.77	<0.01
2. Reliability	5.67	0.99	5.72	0.63	5.35	0.59	4.63	0.01
3. Responsiveness	5.66	0.86	5.72	0.68	5.37	0.54	4.45	0.01
4. Assurance	5.59	0.97	5.72	0.67	5.29	0.59	5.23	0.01
5. Empathy	5.47	0.93	5.68	0.72	5.19	0.66	5.78	<0.01
Total	**5.62**	**0.84**	**5.70**	**0.64**	**5.26**	**0.65**	**7.28**	<0.01

From Table 32, there were differences in mean of perception in service quality overall and in each aspect were compared between sample group with different traveling times (p<0.05). The different pairs found by LSD method were: the group that spends time in traveling for 21-30 minutes and 1-10 minutes and with 11-20 minutes. Therefore, the perception in service quality was different according to the time period that they spend to travel from home to PCU.

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Table 33 Comparison of the mean perception score of overall service quality and each aspect classified by health information received

Perception of Service Quality	Health information received						F-ratio	P-value
	Never		Once in a while		Often			
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	5.15	0.80	5.37	0.68	5.73	0.95	3.84	0.02
2. Reliability	5.03	1.14	5.50	0.58	5.96	0.79	9.98	<0.01
3. Responsiveness	5.26	0.71	5.49	0.59	5.93	0.87	6.96	<0.01
4. Assurance	5.00	0.99	5.44	0.62	5.94	0.78	10.48	<0.01
5. Empathy	5.05	0.94	5.36	0.69	5.75	0.85	5.21	<0.01
Total	**5.10**	**0.86**	**5.43**	**0.57**	**5.85**	**0.79**	**8.05**	<0.01

From Table 33, there was difference in mean of perception in service quality overall and in each aspect between the sample group with different health information received ($p<0.05$). Multiple comparison by using LSD method, found that there are differences in perceived service quality between those who received health information often, and those who never received information and those who received the information once in a while. There was also differences in perceived service quality between the group that received the information once in a while and group that had never received the health information. Therefore, the perception in service quality was different according to the health information received. The one who received information often had perceived service quality higher than those who had never received information and those who received health information once in a while.

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Table 34 Comparison of the mean perception score of overall service quality and in each aspect classified by residential zone

Perception of Service Quality	Residential Zone										F-ratio	P-value
	Zone 1		Zone 2		Zone 3		Zone 4		Zone 5			
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD		
1. Tangibles	5.25	0.56	5.73	0.63	4.89	0.54	6.21	0.73	5.10	0.78	15.29	<0.01
2. Reliability	5.54	0.49	5.75	0.59	4.86	0.47	6.03	0.76	5.28	0.91	8.83	<0.01
3. Responsiveness	5.43	0.48	5.76	0.59	5.05	0.47	6.19	0.77	5.30	0.69	11.75	<0.01
4. Assurance	5.32	0.43	5.79	0.60	4.93	0.45	6.23	0.78	5.20	0.84	15.18	<0.01
5. Empathy	5.23	0.43	5.69	0.73	4.90	0.55	6.11	0.91	5.15	0.81	11.46	<0.01
Total	**5.35**	**0.37**	**5.75**	**0.58**	**4.93**	**0.41**	**6.16**	**0.74**	**5.20**	**0.75**	**15.52**	**<0.01**

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From Table 34, there were differences in perceived service quality between those residing in 5 residential areas ($p<0.05$). Multiple comparison by using LSD methods revealed the differences between those living in Zone1with Zone 2, Zone 3 and with Zone 4, between those living in Zone 2 with Zone 3, Zone 4 and with Zone 5, and between those living in Zone 3 with Zone 4 and with Zone 5. Therefore, the perception in service quality was different according to the residential zone as follows:

- People who lived in Zone 1 had higher perception in service quality than Zone3 at a significant level ($p<0.05$).
- People who lived in Zone 2 had higher perception in service quality than Zone1, Zone 3, and Zone 5 at a significant level ($p<0.05$)
- People who lived in Zone 4 had higher perception in service quality than every zone at a significant level ($p<0.05$)
- People who lived in Zone 3 had less perception in service quality compared to other zones at a significant level ($p<0.05$)

Part 4. Problems and Obstacles in the service of PCU

Table 35 Number and percentage of people in Park Priew Sub-district about services' problems at the PCU.

Services' Problems at the PCU		Number (n=54)	%
1.	Few and far parking spaces	14	25.93
2.	Long time waiting for dispensary services	12	22.22
3.	Limited service area and have not enough chairs	9	16.67
4.	Long time waiting for card to be issue	5	9.26
5.	Few restrooms few and difficult to find	4	7.40
6.	Less Public Relation	2	3.70
7.	Long time waiting for doctor	2	3.70
8.	Follow up appointment is slow	2	3.70
9.	Medication is not good	1	1.85
10.	Officer's service is slow	1	1.85
11.	Cannot see the sign of services	1	1.85

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From table 35, it was shown that total of 54 opinions, there were problems of few and far parking spaces (25.93%), followed by long time waiting for dispensary services (22.22%), limited space and having not enough chairs 16.67%, Long time waiting for card to be issued (9.26%), Few restrooms and difficult to find (7.40%), Less Public Relation (3.70%), Long time waiting for doctor (3.70%), slow appointment (3.70%), Medication is not good (1.85%), Officer's service was slow (1.85%) and cannot see the sign of services (1.85%).

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CHAPTER 5
DISCUSSION

From the study of service quality according to the expectation and perception of the people of Park Priew Sub-district, Urban Area, Saraburi Province, findings generated interesting topics which can be discussed as follows:

1. Comparison of the difference between expectation and Perception from the people of Park Priew Sub-district of the service quality.

1.1 Comparison of the difference between expectation and perception of the people of Park Priew Sub-district in overall service quality.

1.2 Comparison of the differences between expectation and perception from the people of Park Priew Sub-district of the quality of different kind of services.

2. Comparison of the difference between expectation and perception from the people in Park Priew Sub-district about service quality according to characteristics of the population, Traveling time from house to PCU, frequency of service use , health information received and the residence zone.

1. Comparison of the difference between expectation and perception from the people in Park Priew Sub-district about service quality.

1.1 Comparison of the difference between expectation and perception from the people in Park Priew Sub-district about overall service quality.

The differences between expectation and perception from the people of Park Priew Sub-district about service quality are discussed according to the research hypothesis as follows:

First hypothesis: The level of expectation and perception of the people of Park Priew Sub-district about service quality are different

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The results revealed that the expectation of the people of Park Priew Sub-district about the overall service quality was in a high level (mean = 6.84). Actual service feedback from the people of Park Priew Sub-district about overall service quality was also at high level (mean = 5.47), However, with the actual service perception was significantly different ($p < 0.05$) from expectation ($d = 1.37$) which supports the first hypothesis.

This result explains that the service at the primary care unit in Saraburi Hospital is able to respond to the needs of the people in Pak Priew Sub-district at in some level (Zeithaml et al. 1990: 18-20) which can be discussed as follows:

First, in general, people's expectations are higher than the actual service received. (Sathit Wongsawan, 1986: 514-516) This supports the study of Bangaorn Konklang (2004: 43) who found that for the customers from the Infectious Disease Hospital in the Northeast, service expectation was higher than service perception. However, the level of expectation was not in line with the study of Vasinee Singsa (2004: 88), which indicated that the quality of Primary Care Unit of OPD under the Comprehensive Health Assurance Project perception of service quality was higher than the expectation. It may be due to the fact that they used different sample groups.

Second, word of mouth communication and external communication to customers is the factor which affects the expectation (Ziethaml. et al., 1990: 20) which is in line with the comments of Supattra Sriwanichchakorn (2004) that "The beginning of the Comprehensive Heath Assurance Project had public relations from the Government to make people feel more confident in the service that may affect the expectation and perception of the people who used the public health service. The number of the people who used the service has increased as well as the expectation to the service. It reflects that the public relations beginning from the opening of the Primary care unit which is in the urban area of Saraburi Province is not good enough. It is not in accordance with the study of the Sanikarn Srimanee (2004: 77) which showed that the health information received had no relationship to the Primary Care Unit which is located in the health centers that has Saraburi Community Hospital as the main contractor.

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Third, past experience is the factor that affects expectation (Ziethaml, et. al 1990: 20) which is in line with the comment of Johnson and Lyth (cited in Brown, et al. Eds, 1996) that expectation comes form from the previous experience in service. It can be seen that People in Park Priew used the service from the specialist and were not confident with the service of the Primary Care Unit in Saraburi Hospital. They adhere to the service from specialist and cross the step from primary to secondary or tertiary care.

Fourth, service quality gap is not in line with the expectation of the service users and it is not related to the actual service standard which is called “The service performance gap”. This gap happens when the officer cannot implement and/or is not able to adhere to implementation to reach working standards which is caused by role conflicts, lack of training, inappropriate job design (Zeithaml,et al. 1990: 46) This is in accordance with Walker, Churchill & Ford 1977 & Kehn which mentioned that lack of clear roles occur because necessary information for working is inadequate or it may happen from uncertainty when the administrator expects the officer to implement or make the administrator satisfied or does not know the assessment method and compensation. Similarity, Supattra Srivanichchakorn (2004) mentioned that the implementation mechanism and health service system management under the Comprehensive Health Assurance has no opportunities to test the implementation or test the possibility of the established standard and all that resources can do is to explain the policy, implementation standard and primary implementation concept. They cannot explain the concepts in order for the responsible persons to understand clearly. Also, they do not have opportunities to prepare the skills of the human resources for the service. Moreover, the follow-up system and support of Primary Care Unit development followed the previous system which had the role of government inspector, orientation and provincial public health in order to follow up the implementation, visiting system and inspection from the report. It was found that there is limitation of this system because inspectors do not understand the concept and principle of the Primary Care Unit. There were adjustments in stage 2 and 3 of the implementation which led to the adjustment of each health center service every year. It has created confusion and lack of confidence in the implementation, which is in line with the study of Poolsith Sitikarn, et,.al (2002) who found that the

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preparation of human resources to support the primary care unit implementation was not enough because the implementers who worked at the Primary Care Unit did not receive complete training and implementing officer had low level of satisfaction.

For the Primary Care Services in the urban area of Saraburi Hospital, the responsible department is the medical department which is not primary care job. The main tasks of medical department are involved with disease control, health promotion, and curative services, including most of the secondary care and tertiary care.

Fifth, the people in Park Priew Sub-district use criteria to measure differences in service quality from service providers (Zeithaml et al. 1990: 46) which is in line with Kotler (1994) and Bopp, (1990) who mentioned that the service users do not have knowledge or are not a part of a professional technique, As a result, they decide quality from their own perspective while they have interaction with service provider, so called using “Interactive Standard” to assess service quality. This is in accordance with Anuwat Suppachuttikul (1993) who mentioned that in the actual condition, the professional standard quality is only a part of quality because patients who use the service do not care what hospital in Thailand reaches the standard, whether they are in the high level or low level, but they care only when they use the service, i.e. what kind of treatment will they get, whether it is appropriate and safe, does the officer provide good care and whether the service matches their expectation or not. When the interaction between service provider and service user is satisfied from both sides, It is perceived as the service quality. This is in line with Sriporn Tuntipulvinai (1995) who mentioned that the one who succeeds in operating the hospital business should follow technical and interactive standards, which is also in accordance with the study of Patcharee Thongpae (1997) which found that the outstanding Community Hospital have characteristics by the structure standard of the Ministry of Public Health. However, if it does not follow the interactive standard of the patient, the patient will realize that service has no quality like what McNealy Said (1993) that the established quality by the customers or service user.

Therefore, the service users need to know whether the actual service is in the same level as their expectation or exceed their expectation. Moreover, they must give importance to public relations. To have interaction with the

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service user to create word of mouth communication, the service user must know and understand the difference between family, culture, tradition, personal beliefs and tastes because all of these are related to the quality of the service user's expectation (Zeithaml,et al.1990: 37).

When the people participate for better health service system development, the last target of the health system development should be for people to have a role in improving the health service system (Saguan Nittayarumpong, 1997).

1.2 The comparison of the difference between the expectation and the perception of the people in Park Priew Sub-district about the service quality in each aspect.

The results revealed that the expectation of people in Park Priew Sub-district about service quality in each aspect and actual perception from those people about service quality in each aspect was significantly different at a high level ($p < 0.05$). The mean of perception of service quality was lower than the mean of expectation, which supports the first hypothesis.

Tangibles

People in Park Priew Sub-district have expectation (mean = 6.84) which is higher than the actual service (mean = 5.41) at the level of significance ($p < 0.05$) with the difference of 1.43. If the mean is high in any aspect, it means that the Tangible Condition of Service is the most important. The result can be discussed as follows:

Service is different from the product where service is intangible. It cannot be seen or know in advance that what the service is such as performance of medical service which is shown as performance and differs from product because it cannot be touched or seen and cannot be measured or tested directly so that it is difficult to assess and inspect the quality. Therefore, service provider must find guarantees for the patient to be self-confident and to make a decision to use the service by having the principles as follows: (1) Place should be able to create the confidence and convenience to the patient and waiting period should not take long. (2) People should dress appropriately, have a good personality, smile,

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speak pleasantly for the patient to be impressed and the quantity of the job should not be too much (3) Equipment should be updated and have high performance, fast service for the satisfaction of the service users. (4) Communication Material: the media should be in line with the presented service and the service users and communication should be efficient and fast. (5) Symbols, brand name or trademark of the service should be clear (6) Price: price setting, service providing should be appropriate to the level of the service, clear and easy to separate the level of the service (Kotler, 2000). This is in line with Markland et al., 1998 who said that the tangibles of the product and service may be different in each organization. The health service has intangibles around 25% and tangibles around 75% which is the behavior of the service provider towards the service user.

This research reflects that the tangibles of the service have problems in the point of view of the people in Park Priew. Not only the nursing service at the Primary Care Unit that was set, but also other facilities such as cooler, newspaper, television and leaflets that provide health knowledge. In the morning, there are a lot of services users waiting for the service and have to wait for a long time but if they have these materials, it will make them relax and enjoy while waiting.

This research is in contrast with the study of Wanrudee Phuthong who found that service quality that the evaluator knew the service tangibles has the lesser problems.

Empathy

People in Park Priew Sub-district have expectation (mean = 6.80) which is higher than the actual service (mean = 5.40) at the level of significance ($p < 0.05$) with the difference of 1.40. This result reflects that the empathy to the service users has a lot of problems aside from the tangibles in the point of view of the people in Park Priew Sub-district due to

Inseparability means the production, delivery and service receiving that happens at the same time. Service users have a lot of participation in the production process. They have an important role in producing quality and are always related to human resources of the service department. The services of the service's provider have specific characteristics that cannot be replaced by someone, because

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they have to produce and to do all of them at the same time. These cause a high work load in a very limitation of time (Kotler, 2000). The providers are always in a hurry, have to compete within the time, and do not have enough time to listen to the sufferings, have uncomfortable feeling of the health problems of the service users. These may cause service users to feel that the officers do not understand their feelings. If the officers express empathy and take care of the illness condition, pay attention to the suffering of the health and understand the needs of the people's health in the area to help and to solve the problems in disease or medication and provide the same service to everyone, these behaviors will reduce the serious emotions that happen due to the illness of the patient and relatives. These feelings are worry, pain, suffering, feeling of sickness, which is in line with Anuwat Suppachutikul (1993) who said that the actual condition in the quality by the profession standard is one part of the quality but not all of it because patients who use the service do not care, what standard do the organization have. They just care about when they get the service, will the officer take care of them and whether the service will be appropriate and safe and reach their expectations or not. However, if the interrelation between service users and service provider is good, both of them are satisfied, the service that they provide is the quality service by the perception of the service user.

Assurance

People in Park Priew Sub-district had expectation (mean = 6.86) higher than the actual perception (mean = 5.48) at the level of significance ($p < 0.05$) with the difference of 1.38. The difference is high and ranked in the third level from 5 aspects.

The service at the Primary Care Unit has limited time; there are a lot of service users. The officers who serve the patients are not enough and cannot cover and complete all areas by the expectation of the service user. The service user will feel confident that they get good service and safety from doctors and nurses who provide the treatment (Youssef et al., 1996: 15-28). Nurses have a major role to relieve the patient from the illness. The nursing service that service providers provide

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should be from the ones who have skills, ability and make service users trust in getting the service (Bopp, 1990: 6-16)

Reliability

People in Park Priew Sub-district have a high level of expectation in Reliability (mean = 6.85) which was higher that the actual service (mean = 5.53) at a significant level ($p < 0.05$). The mean point difference was 1.32 and the difference ranked high in the 4th level from 5 aspects. It can be discussed that as doctors and nurses who provided that service in the Primary Care Unit can make the service users rely on the treatment which is appropriate at certain levels but it is not according to the entire expectation of the service users. Service users assess the service that the service should be reliable, no hassle and can take care and help the patient to be relieved (Youssef et al., 1996: 15 -28), however the service in the PCU is limited. Limit number of nurses and have to rush in working to compete within the time, so that they can explain about the nursing treatment to the service user to be clear understanding and trust in the treatment without doubts.

Responsiveness

People in Park Priew Sub-district have a high level of expectation in Reliability (mean = 6.85) which was higher that the actual service (mean = 5.54) at a significant level ($p < 0.005$). The mean point difference was 1.31and the difference is low in any aspects**.** It can be discussed that as doctors and nurses who provided that service in the Primary Care Unit can respond the service users better than any aspects but it is not according to the entire expectation of the service users.), however the service in the PCU is limited. Limit number of nurses and have to rush in working to compete within the time,

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2. Comparison of the difference between expectation and perception of the people in Park Priew Sub-district about service quality according to the characteristics of the population and frequency of service use and traveling time from house to PCU, health information received and residence zone.

The results are discussed according to the second and third hypothesis as follows:

Secound hypothesis: The service users who have different characteristics such as gender, age, marital status, education, occupation, monthly average income, frequency of service use, information received, Traveling time from house to PCU and residence zone have different expectations in service quality.

Third hypothesis: Service users who have different characteristics such as gender, age, marital status, education, occupation, monthly average income, frequency of service use, information received, Traveling time from house to PCU and different resident zones have different perceptions of service quality.

The results revealed that

People with differences in gender, age, marital status, occupation , monthly household income, frequency of use, had not different expectation and perception in service quality.

People who have different education levels, traveling time from home to PCU, health information received, residence zones (1-5) had different expectation and perception in service quality. This result can explain as follow.

2.1 Gender

The results show that different genders have no different expectation and perception in service ($p > 0.05$) which does not support the second and third hypothesis, This is in line with the study of Sunee Chareonkul (2000: 74) who found that male and female have no differences in expectation to the implementation of the Saraburi Regional Hospital. This is in accordance with the study of Sanikarn Srimanee (2004: 73) who found that gender has no relationship to the service users of

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the Primary Care Unit which is located in the Health Center which Saraburi Community Hospital is the main contractor. But, it is not in line with Doungporn Rattanaamornchai (1992) who found that males had opportunities to receive information and participated in the health activities and social much more than females, and it is not in line with Ueamdeuan Keawsawang (2004: 98) who found that gender is the variable that affects service quality assessment.

This research explains that males and females have equal rights in order to take care of their own health. Even though males have high score in Reliability because males expect the service provider to have enough knowledge and abilities to serve the service users to get good and appropriate service. Females have high expectation in response to the service user because females expect that if the service provider has good relationship, pleasant talk, polite manners and willingness to provide service and release some of the stress (Nantawan Liampreecha, 1995: 24-30). However, males' and females' expectation in received service are the same and the Primary Care Unit service setting. Therefore, expectation and perception is not different by the gender of the Primary Care Unit service users in the urban area of Saraburi Province.

2.2 Age

The results indicate that people in Park Priew Sub-district who have different ages do not have different expectations and perception about service quality ($p > 0.05$) which does not support the second and third hypothesis. It is in line with the study of Sunee Chareonkul (2000: 79) who found that age has no relationship to the implementation of the service at Saraburi Regional Hospital. However, it is in line with the study of Sanikarn Srimanee (2004: 75) who found out that age has a positive relationship with satisfaction of the Primary Care Unit which is located in the Health Center with Saraburi Community Hospital as the major contractor. Even though age is the most important factor to the person's opinion that is from different generations, people will use reason in thinking and when age changes, expectation and satisfaction change also. It also depends on the experience and learning of the people (Tassana Boonthong, 1986). Therefore, people in Park Priew Sub-district who have different

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ages do not have different expectations and perception of service quality at the Primary Care Unit in urban area of Saraburi Province.

2.3 Marital Status

The results show that for people in Park Priew Sub-district who have different marital status, perception in service quality are not different ($p > 0.05$) which does not support the second and third hypothesis. This is not in line with the study of Suangthip Wongphan (1998: 95) who found that the service users who have different marital status, the expectations and perception in service quality at the OPD of the Public Hospital in Suphanburi are not different. This contradicts with the study of Supattra Liamwarangkul (1997: 90) who's revealed that the service users who work in the physical equipment of Sirindhorn Center who were married have a different service perception from the ones who are single. It can be the setting responsibility that causes them to know their rights, know their obligation and to express by their behavior by their status that they receive but the result of the study explained that service of Primary Care Unit in Urban Area, Saraburi Hospital can provide service according to service user. Service users may have no differences in service perception. Therefore, Park Priew people who have different marital status do not have different expectations and perception to the service quality of the Primary Care Unit.

2.4 Educational level

The results indicate that people in Park Priew Sub-district with different education levels have different expectations and perception ($p < 0.05$) which supports the second and third hypothesis. It is in line with the study of Sunee Chareonkul (2000: 78) who found that educational level is related to the expectation of the implementation of Saraburi Regional Hospital, this is also in agreement with French (1976: 6) who found that the ones who have higher education have a higher expectation than the ones who have lower education, but this is not in line with the study of Banjamas Sirikamolsatien (1999: 46) who found that the patients who have different levels of education have no difference in satisfaction to the service in Somdej Phra Yupparaj Hospital, Amphur Dejudom, Ubonrajjathani Province.

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This research can explain that education is fundamental for the person to have different opinions and can help to be able to understand the situation which affects the expectation of the service user. Service users always expect that public hospitals have good service to the people and should have officers who can recommend and have friendly service, and take care of the service users with willingness. The one who has high education has a higher expectation to the medical service than the one who has lower education (French 1976: 6). Therefore, Park Priew people who have different education levels have different expectation and perception about service quality at Primary Care Unit.

2.5 Occupation

The results indicate that people in Park Priew Sub-district who have different occupations have no difference in service quality expectation ($p>0.05$) which does not support the second and third hypothesis. The results are agreement with Suangthip Wongphan (1998: 93) who found that the service users who have different occupations do not have different expectation and perception at the OPD at the Suphanburi Public Hospital. This is also in accordance with Sunee Chareonkul (2000: 79) who found that occupation has no relationship to the implementation of Saraburi Regional Hospital. However, this concept does not agree with Vasinee singsa (2004: 90) who found that service users at OPD who have different occupations under the Comprehensive Health Assurance Project in Nonthaburi have differences in service quality perception. Even though occupation is one of the effective factors from the social and environment that has perception result by Sathit Wongsawan (1986: 194) who mentioned that the effect from the social and internal environment causes the person in the society to have a different perception. The result of this education explains that the Primary Care Unit service established in Saraburi Hospital can serve people equally in every occupation. Therefore, Park Priew people who have different occupations do not have a different expectation and perception of the service quality of the PCU.

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2.6 Monthly Household Income

The results indicate that Park Priew people who have different mean incomes do not differ in expectation and perception ($p > 0.05$) which is not in line with the second and third hypothesis. This is in line with Sanikarn Srimanee (2004: 74) who found that monthly household income has no relationship to the satisfaction of the service user who use the service at the Primary Care Unit in the Health Center with Saraburi Community Hospital as the major contractor. It is in line with Sunee Chareonkul (2000: 79) who found that income has no relationship to the expectation in the implementation of the Saraburi Regional Hospital, which also agrees with Vasinee singsa (2004: 92) who found that service users at the OPD who have different incomes under the Comprehensive Health Assurance have no differences in service perception. It is not in line with Kobkul Phanchareonworakul (Ref.) who mentioned that income or status in economics is the indicator to tell the economic and social status which is one of the factors that make perception different. This is also not in line with the study of Supattra Liamwarangkul (1997: 90) who found that service users of physical equipment at Sirindhorn Center have no differences in service quality perception. Whether the service user had high or low income, everyone expected that when they used the service at the public hospital, they should get good service, good quality, correct according to the technique of professional standards and appropriate to the sickness. The mentioned come from the word of mouth that public hospital has been developed for better service. Service users have no different expectation and they have card (Gold Card 30 baht) which client has to pay 30 baht for using the service that make the service user feel that it is not too expensive and they can pay without any effect to the family. Therefore, Park Priew people who have different monthly income do not have different expectation and perception about service quality of the PCU.

2.7 Frequency of use/ experience in using the service

The results indicate that Park Priew people who have different frequency of use do not have different expectation and perception in service quality ($p > 0.05$), which does not accept the second and third hypothesis. This is in accordance with the study of Lukhana Siriratapolkul (2000: 101). The results revealed

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that experience that the guarantor used in Admit Patient Service at Lerdsin Hospital has no relationship to the satisfaction whenever the service user is using the service, they will get the same thing. This is in line with the study of Somporn Tungsom (1993) which showed that the experience in using service from other health center has no relationship to the level of satisfaction to the medical service. This does not agree with Johnson & Lyth In Brown et al., Eds., (1991: 181-182) and Folkes, In Rust & Oliver., Eds., (1994: 108-110) who mentioned that the service user use the service according to what they gained from past experience. If the service user is satisfied, they will come back for the service. Nantawan Liampreecha (1995: 25) mentioned that each service provider has a different way in service even it comes from the same person but if it is on different occasions then the service will be different. If the result of the service is not good, the service user is not satisfied and will not come back again. This research explains that the Primary Care Unit in Urban Area, Saraburi Hospital has developed the quality continuously by being responsible with the needs of the service users as a principle. No matter how many times they use the service, it will be the same every time. Therefore, people in Park Priew Sub-district who have different frequency of use are not different in expectation and perception in the services of PCU.

2.8 Traveling time from home to the PCU.

The results show that people in Park Priew Sub-district who spend different amounts of time to travel from home to PCU have different expectation and perception in service quality ($p < 0.05$), which is in line with the second and third hypothesis. This is in accordance with the study of Sunee Chareonkul (2000: 80). The results revealed that the distance from house to the hospital had a relationship to the expectation in implementation of Saraburi Regional Hospital but it is not in line with Sanikarn Srimanee (2004: 77) who found that the time used in traveling had no relationship with the satisfaction of the ones who used the service of Community Health Center that is located in the Health Center with Saraburi Community Hospital as a major contractor. The result can be explained by the fact that people who live close to the hospital have the opportunity to know the information and limitation of the Saraburi Hospital much more than the ones who live far away from the hospital

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because the expectation of these people come from previous experience. The word of mouth of the person's needs and information received from the service provider (Ziethaml, et. Al 1990: 19) in this research may cause the one who receive the health information from the hospital often because they are close to the hospital have expectation that match reality much more than the ones who live far away and do not always get the information from the hospital. Therefore, Park Priew people who spend different amounts of time from home to the PCU have different expectations and perception of the service quality of the PCU.

2.9 Health information received

The results showed that the Park Priew people who receive different health information have different expectation and perception ($p < 0.05$) which agrees with the second and third hypothesis. and in line with the study of Sunee Chareonkul (2000: 81). It was found that the health information received has a relationship to the expectation of the implementation of Saraburi Regional Hospital. It is not in line with Sanikarn Srimanee (2004: 77) found that health information received has no relationship to the satisfaction of the service use at the Primary Care Unit which is located in the Health Centers with Community Hospital in Saraburi Province as the major contractor. The results explain that service users need the necessary information to reduce worry and create satisfaction in service. Therefore, Park Priew people who get different health information have different expectation and perception in service quality of the PCU.

2.10 Residence Zone

The result found that Park Priew people who lives in different zone has different expectation and perception in overall ($p < 0.05$) which agrees with the second and third hypothesis. Even though Park Priew people lives in the zone that Saraburi was set for the convenience in service but they still use the service at the Primary Care Unit in the urban area, Saraburi Province, which has the same place for the parking lot, service and medication room but the expectation and perception in the actual service quality is different which can be explained by the living conditions, culture, traditions, and values that make the person who live in different zones have

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different perception in service (Gunya Suwansaeng: 1993: 135). The expectation of the service users vary according to the attitude of each person, experience from service and received information from the service provider (Oberst,1984: 2363-2373).

The people in Zone 4 have a lower expectation in service quality than every other zone and has actual service quality perception ($p < 0.05$) which can be explained by the fact that Zone 4 area is a rural area which Supattra Suparp (1993: 22-24) state that the values of the upcountry people will accept what they get without argument, believe in the one who has authority, be the receivers much more than aggressors which means no conflict with anyone, get scared rather than be brave, like to obey much more than argue, hope in happiness, interested in what is there at that time, do not want anything more than what they have and do not care or ask questions that is beyond their ability. From the above-mentioned reasons, it caused the service users in Zone 4 easy to reach than others. Moreover, Zone 4 has readiness much more than others because the responsibility is for primary care only, while others have to do medical society along with their activities.

Because the service users do not have knowledge in professional technique to assess the professional quality, therefore they use standards to set the quality by their own point of view by assessing the quality while they have interaction with the service providers. It can be concluded that this research has interactive marketing the standard in service quality (Kovner and Smith, 1978 and Kotler, 1994) even though the other 4 zones have the right structural characteristics according to the Ministry of Public Health. If they do not follow the interactive standard of the service user, they will know that the service has no quality like McNealy (1993) said the quality was set by the customer or service users.

For the Zone 5 area, the condition is upcountry and the service provider is the same team with Zone 4 but the people who use to register for the Comprehensive Health Assurance with Kasemrad Hospital are still used to the private hospital. The expectation and perception is high and the perception in service is low as in the 2nd ranking aside from the people from Zone 3. Moreover service users who are transferred from Kasemrad Hospital have less interaction.

In the case of Zone 3, where the people have high expectation higher than every other zone and have perception lower than every zone, it can be explained

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that Zone 3 is a commercial place, is civilized and it is hard to reach the people. Moreover, most of the people have the profession to do their business and have high income. The ones who have their own business have a good status and may get the service from clinics or private hospitals. When they use the public hospital, they compare automatically. The people who have high income have a higher opportunity to choose the health service location that has better performance than the location for the low income earners. In the Zone 3 that consists of the ones with high education which French 1976: 6 mentioned that the one who has high education also expects more from the medical service than lower income people and education is the fundamental in making the people have a different opinion and can help them to consider the situation reasonably.

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CHAPTER 6
CONCLUSION

This research is an exploratory cross-section research. The objective was to study service quality according to the expectation and perception of the 263 people in Park Priew Sub- district, Amphur Muang, Saraburi Province. The period of data collection was from March 1-31, 2005. The research instrument was the questionnaire that this researcher designed with the examination of the content validity from the experts. The questionnaire was tried out with 30 people in Dao Reung Sub- district, Amphur Muang, Saraburi Province who used the service at the Dao Reung Primary Care Unit, the reliability value of expectation and service perception were 0.97 and 0.93 respectively. Analysis was done by using program computer to compute for the statistics value, frequency, percentage, mean, standard deviation. Analytical statistics to compare the mean score of the expectation and perception of the people in Park Priew about service quality by using paired t-test, t-test, One way Analysis of Variance and LSD.

Research Conclusion

1. General information of the sample group.

It has been observed that among the Park Priew people who are sample families, totaling 263 households, most of the interviewees are female 71.9%, aged 41-50 years old 26.6%, married 72.2%, elementary school education 26.2%, occupation: unemployed/ housewife 35.4%, monthly household income between 5,001-8,000 baht 31.6%, have the Comprehensive Health Assurance (Gold Card) benefit 69.2%, the maximum frequency of use is more than 10 times 51.33%. The motivation to come to the primary care unit is its proximity to the home 47.91%,

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traveling time spent from home to primary care unit is 21-30 minutes 32.8% and receive health information once in a while 63.0%.

2. The results were analyzed for the level of expectation and perception of Park Priew people about service quality.

The expectation level of Park Priew people about the service quality in the Community Health Center in the Urban Area, Saraburi Province overall was in the high level, the average = 6.83% when separated according to each aspect was in the high level in 5 aspects which are: tangibles, reliability, responsiveness, assurance and empathy.

The level of perception of the people in Park Priew about the service in the Community Health Center in the Urban Area, Saraburi Province is in the high level with an average point = 5.47%. When divided into each aspect, it was found that they were in the high level in 5 aspects. When the expectation and perception of Park Priew people about service quality is compared, it reveals that average expectation is higher than perception overall ($p < 0.05$) and each aspect ($p< 0.05$)

3. Analysis results to compare the expectation and perception of the people in Park Priew about the service quality, separated by the population characteristics, frequency of use, traveling time, health information receiving and residence zone:

Males have expectation (mean = 6.84) higher than females. The expectation about service quality is not different in gender ($p = 0.91$). Those who are married have the highest expectation (mean = 6.85). Comparison of the average point of the marital status shows that there was no difference ($p = 0.49$). The range of the age between 31-40 years old has the highest expectation (mean = 6.94). When the age of 5 groups was compared, it revealed no difference in expectation ($p = 0.47$). The occupation that has highest expectation (mean = 6.89) is commercial/ business owner which has a high average. Upon comparison of occupation in 4 groups, it is noted that there was no difference ($p = 0.59$). Those with average household income of 5,001 – 8,000 baht have the highest expectation (mean = 6.89). Comparison of the average of 4 groups indicates that they are not different ($p = 0.28$). Frequency of use

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1-10 times has the highest average of expectation (mean = 6.86). Comparison of the average of 2 groups there was no difference (p = 0.72). Park Priew people who have never used the service have the highest expectation (mean = 6.77). In terms of responsiveness, the group that used the service before has the highest expectation (mean = 6.84) in terms of assurance. When the average points of these groups were compared, it showed that there was no difference (p = 0.19). Therefore, Park Priew people who have different gender, marital status, age, occupation, average monthly income, frequency of use do not differ in service quality expectation.

Males have lower average in perception than females which was 5.38 but the expectation in service quality was not different (p = 0.27). Those younger than 30 years old have the lowest average (mean = 5.15). When the 5 groups were compared, it can be found that there was no difference (p = 0.08). Those who are Single / Divorce / Widow have the lowest average = 5.34. When the average of 2 groups were compared, there is no difference (p = 0.51). Commercial/ business owners have the lowest perception which was 5.35. Comparison of the average points of 4 groups indicate no difference (p = 0.49). Those with average monthly household income of 5,001 – 8,000 baht have the lowest average perception which was 5.30. Comparison of the average value shows that there was no difference (p = 0.05). Frequency of use more than 10 times has the highest average of perception (mean = 5.46). Comparison of the average value shows that there was no difference (p = 0.89). Park Priew people have lowest perception (mean = 5.40) in understanding and empathy. Therefore, Park Priew people who have different gender, age, marital status, occupation, monthly income and frequency of use were not different in terms of perception of service quality.

People in the sample group with education in bachelor degree level or higher have the highest average expectation which was 6.95. Comparison of the expectation of the 6 groups reveals that there are significant differences ($p < 0.05$). Those who have no education have less expectation among all the groups.

The sample group that spends time to travel from home to the primary care unit 21-30 minutes has an average expectation of 6.92. Comparison of the expectation of 3 groups indicates that there are significant differences ($p < 0.05$).

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The group that spends 1-10 minutes has a lower average expectation than the group that spends 11-20 minutes and less than the group that spends 21-30 minutes.

The sample group who never received health information has the highest expectation which was 6.94. Comparison of the expectation of 3 groups shows that there are significant differences ($p < 0.05$). The group that has never received health information has higher expectation than the one that receives information once in a while and the group that always receives information. Those who receive information once in a while have a higher expectation than the group that always receives the information.

The sample group who lives in Zone 3 has the highest average which was 6.98. Comparison of the average expectation of the 5 groups indicates that there was a difference at a significant level ($p < 0.05$) in Zone 4 with every zone.

Therefore, Park Priew people who have different educational levels, residence zones, health information received and traveling time from home to the primary care unit have different expectations in service quality.

The sample groups with associate degree level in education have the lowest expectation which was 5.25. A comparison of the perception average in 6 groups reveals that there was a significant difference ($p < 0.05$). The group who is not educated has a higher average point in perception than the other groups.

The sample group who spends 21-30 minutes to travel from home to the primary care unit has the lowest average point in perception = 5.26. A comparison of the perception of 3 groups shows a significant difference ($p < 0.05$). The group who spends 21-30 minutes from home to the primary care unit has a lower average point in perception than the group who spend 1-10 minutes and 11-20 minutes.

The sample group who has never received health information has the lowest average point of perception = 5.10. Comparison of the average of perception of 3 groups reveals that there is a significant difference ($p < 0.05$). The group who has never received health information has a lower average than the group who receives information once in a while and the group that receives information once in a while group has a lower perception than the one who always receive it.

The sample group who lives in Zone 3 has the lowest in perception which was 4.93. When the 5 groups were compared, there was a significant difference

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($p < 0.05$). The different were found between the average of perception of the sample group in Zone 3 is lowest than every other zone and Zone 4 is highest than every other zone, therefore Zone 2 is higher than Zone 1 and Zone 5.

Therefore, Park Priew People with different education, residence zone, health information received and traveling time from home to primary care unit have different perceptions about service quality.

Recommendation

From the results, it can be gathered that expectation of the service user has higher average in every aspect. Therefore, in providing the service, Primary Care Unit, Saraburi Hospital should have a quality according to the expectation and perception of the people. Thus it should have service improvement as follows:

1. It should be Improved Tangibles service (1) Place should be able to create the confidence and convenience to the patient and waiting period should not take long. (2) People should dress appropriately, have a good personality, smile, speak pleasantly for the patient to be impressed and the quantity of the job should not be too much (3) Equipment should be updated and have high performance, fast service for the satisfaction of the service users. (4) Communication Material: the media should be in line with the presented service and the service users and communication should be efficient and fast. (5) Symbols, brand name or trademark of the service should be clear (6) Price: price setting, service providing should be appropriate to the level of the service, clear and easy to separate the level of the service

2. It should have more public relations and provide information to the people in Park Priew to know the actual information about:

2.1 Objectives of the establishment of the Primary Care Unit in the Urban Area which is located in Saraburi Province.

2.2 Characteristics and service processes.

2.3 Difference between PCU and OPD.

2.4 Advantages to the Park Priew people if they use service at the Primary Care Unit in the Urban Area with other place.

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This can be done through the media such as news tower, community radio and television, local newspapers, posters, leaflets and public relations for the service users in each zone and especially those who live far away from the primary care unit. The PCU may set up group discussions and exhibitions in the community.

Since the needs and expectation of each service user is different, even though service provider has ability to provide service, it cannot respond to all the needs of the service users. If there is any service that the service provider thinks is inappropriate or it cannot manage, it should be communicated well according to the expectation of the service users that will create the same understanding between the service providers and service users.

3. It should have a plan for human resources potential development in every level. Due to fact that every human resource is the one of the important parts in creating the image of the Primary Care Unit, it should provide additional and updated knowledge and should have continuous assessment.

3.1 Knowledge and understanding in the Primary Care Unit. To take care of the people by combining the knowledge in psychology, behavioral sciences whether in health promotion, disease prevention, treatment, rehabilitation or coordination with the related parties by focusing on continuity. It should carry out its duties and responsibilities efficiently that will make the service users trust and feel confident that they can get quality service with reliability.

3.2 In terms of knowledge and understanding in the job duties, it should have the spirit of service and the ability respond to the service user with readiness and willingness, friendliness, empathy to the service user and understand the different feelings of each service user. It is important for service user at Park Priew be impressed and to recall the primary care unit as the first place to get the service next time and coordinate with the PCU in order to do promote health rather than to cure it.

3.3 Participatory Learning for Health Development because for the health promotion to succeed, people must realize their health problems and participate in every step of development.

4. The results have shown that factors in education level, traveling time spent from home to primary care unit, health information received and residence zone

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of the Park Priew affect the perception of service quality. Established service should be concerned with:

4.1 Differences in educational level. People with a bachelor's degree or higher have a higher expectation from the service provider than those with a lower level of education. The service provider should be willing and ready to serve the patient immediately but efficiently according to the needs of the service users. If there are limitations in the service, they must be communicated efficiently so that the service users can adjust their expectation according to the reality. The treatment should be explained until the service user can trust that it is appropriate and correct by focusing on the treatment and focusing on the recommendations before discharge, indicating the exact schedule of services to the patients and relatives for the health promotion to be in line with the culture, traditions and values of each service user.

4.2 Differences in traveling time and received information, especially the group that is far away form the primary care unit and have to spend long time on the street will have less opportunity to receive information from the primary care unit than other groups. Therefore, service provider in each zone should focus on public relations including focusing on building the relationship with the community leaders and stakeholder of the community such as monks, senior citizens, respected members of the community, etc. by extending the period for initiating action. Service providers in each zone can make the people that live far away feel as if they are closer, understanding their conditions of life, society and needs in the same way as the ones who are nearby.

4.3 Differences in residence zone, especially for those who live in Zone 3 that have higher expectation in service quality than every other zone and have lower perception than every zone, the implementation should be:

- Add more frequency in public relations about the Primary Care Unit in the Urban Area in every aspect and focus on the benefits that people will get if they use the service at the Primary Care Unit in Urban Area including the reliability of the implementer.
- Service provider in the zone must make the people understand so that they can adjust their expectations according to the facts.

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- Focus on building relationships with the stakeholder in the community such as senators, committee of chiness temple, instructors / professors, Tai Chi committe and the respected people by extending the time to work on the period of initiating action. Service provider should be able to make people in Zone 3 feel close, understand the condition of life, society, and needs including the officer should be the one who is important to the people.
- The Administrator should extend the period in using the vehicle and driver to be more efficient in working.
- The Administrator should develop the knowledge and ability of the service provider in Zone 3 and focus on knowledge about psychology, social science and participation with the community.
- The Administrator should be close to the implementer in Zone3 to know more about the problems, obstacles and comments to have a tangible implementation guide for supporting providing help which is in line with the needs of the implementer in Zone 3.
- The Administrator should have clear targets, indicators and assessment concepts for the implementer in Zone 3.

For the readiness of the officer in Zones 1, 2 and 3 to be more responsive to the people, the administrator should review the performance of the implementation by classifying the medical social workers out of PCU. They can test them for 6 months and assess the results before and after implantation but must have clear measured indicators.

On the day that the center has many service users, the officers from other zones should come and help and let them give the suggestions before going back home, how to take medication, following the doctor’s orders seriously because to provide the service at this point will help in creating the health promotion to be more tangible, and the zone officer can be close to the people and to collect useful information to work with the people in their responsibility area.

5. There should be coordination with the other working groups related to the services in the Primary Care Unit.

5.1 Pharmacy group regarding the issue that dispensary is always closed and the long waiting time for the medication

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5.2 Card room: slow card issuance.

5.3 High level administrator should know about small space, not enough seats, less convenient facilities as the service users are increasing.

6. There should be periodic evaluations of the service quality according to the expectation and perception of the people of Park Priew Sub-district, by creating the standards to establish interactive standard as a conceptual framework to consider the quality of the Primary Care Unit with a technical standard/professional standard.

Suggestion for the future research

1. There should be a study in the service quality according to the expectation and perception of the Primary Care Unit service user in which Saraburi Hospital is the main contractor.

2. There should be a study of the other factors that affect the expectation and perception of the Park Priew people under the concept of Zeithaml, Parasuraman and Berry.

3. Job satisfaction of every service provider and atmosphere of the organization in the Primary Care Unit in the Urban Area should be studied.

4. There should be a study on the model of the Primary Care Unit in the City that is appropriate for the Park Priew people.

5. There should be a study about the service quality according to the expectation and perception of the Primary Care Unit in the cities of other provinces to compare how service quality differs from Saraburi Province.

6. There should be a study about the service quality of admitted patients of Saraburi Hospital according to the expectation and perception of the people of Park Priew in order to get complete information of the inpatients and outpatients.

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APPENDIX

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THE LIST PANAL OF EXPERTS

1. Assoc. Prof. Bhusita Intaraprasong, Ph.D.
   Faculty of Public Health,
   Mahidol University.

2. Asst. Prof. Wonpen Kaewpan, Dr.PH.
   Faculty of Public Health,
   Mahidol University.

3. Dr. Anan Kamolnate, M.D.
   Chife of Health Service Development Department
   Saraburi Hospital

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แบบสอบถาม

เรื่อง

คุณภาพบริการตามความคาดหวังและการรับรู้ของผู้รับบริการ

ในศูนย์สุขภาพชุมชนเขตเมือง โรงพยาบาลสระบุรี

แบบสอบถามชุดนี้ เป็นการประเมินคุณภาพบริการของศูนย์สุขภาพชุมชนเขตเมือง โรงพยาบาลสระบุรี โดยประชาชน ตำบลปากเพรียว คำตอบที่ได้จะเป็นประโยชน์อย่างยิ่งต่อการนำมาปรับปรุงคุณภาพการบริการของศูนย์สุขภาพชุมชนเขตเมืองโรงพยาบาลสระบุรี ให้สอดคล้องกับความต้องการและความคาดหวังของท่านที่มีต่อบริการของโรงพยาบาลสระบุรี ดังนั้นจึงขอความกรุณาให้ท่านช่วยตอบคำถามให้ครบถ้วนทุกข้อและท่านสามารถให้ข้อคิดเห็นในการให้บริการของศูนย์สุขภาพชุมชน เขตเมือง โรงพยาบาลสระบุรี ตามที่ท่านเห็นสมควร คำตอบของท่านจะถูกเก็บเป็นความลับและจะไม่มีผลต่อการบริการหรือการรักษาพยาบาลที่ท่านจะได้รับ

แบบสอบถามมี 3 ส่วน ดังนี้

ส่วนที่ 1: ข้อมูลทั่วไปของผู้ตอบแบบสอบถาม

ส่วนที่ 2: ความคาดหวังและการรับรู้บริการของประชาชน ตำบลปากเพรียว

ส่วนที่ 3: ปัญหา อุปสรรคและข้อเสนอแนะในการบริการของศูนย์สุขภาพชุมชน เขตเมือง โรงพยาบาลสระบุรี

ขอขอบพระคุณทุกท่าน

ศิริพร สิทธิโชคธรรม

ผู้วิจัย

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ส่วนที่ 1 ข้อมูลทั่วไปของผู้ตอบแบบสอบถาม

<u>คำชี้แจง</u> โปรดทำเครื่องหมาย ✓ลงใน ( ) หน้าข้อความที่เป็นจริงเกี่ยวกับตัวท่าน และเติมคำลงในช่องว่างให้สมบูรณ์

1. โซนที่ท่านอยู่

( ) 1. โซน 1 ( ) 2. โซน 2 ( ) 3. โซน 3

( ) 4. โซน 4 ( ) 5. โซน 5

2. เพศ

( ) 1. ชาย ( ) 2. หญิง

3. ขณะนี้ท่านมีอายุ……..ปี (ถ้าเศษเกิน 6 เดือนให้นับเป็นปีถัดไป)

4. ปัจจุบันสถานภาพสมรสของท่าน คือ ข้อใด?

( ) 1. โสด ( ) 2. คู่ ( ) 3. หย่า

( ) 4. หม้าย ( ) 5. แยกกันอยู่

5. ระดับการศึกษาสูงสุดของท่านคือ ข้อใด?

( ) 1. ไม่ได้เรียนหนังสือ ( ) 2. ประถมศึกษา ( ) 3. มัธยมศึกษาตอนต้น

( ) 4. มัธยมศึกษาตอนปลาย/ปวช. ( ) 5. อนุปริญญา/ประกาศนียบัตร

( ) 6. ปริญญาตรี ( ) 7. สูงกว่าปริญญาตรี ( )8. อื่นๆ ระบุ…….

6. ปัจจุบันท่านประกอบอาชีพ อะไร?

( ) 1. รับราชการ ( ) 2. พนักงานรัฐวิสาหกิจ ( ) 3. รับจ้างรายวัน

( ) 4. เกษตรกร ( ) 5. ค้าขาย ( ) 6. ธุรกิจส่วนตัว ระบุ…….

( ) 7. ว่างงาน ( ) 8. พนักงานบริษัทเอกชน ( ) 9. แม่บ้าน/พ่อบ้าน

( ) 10. อื่นๆ ระบุ……

7. ท่านมีรายได้เฉลี่ย<u>ของครอบครัว</u>ต่อเดือน เท่าไร?

( ) 1. น้อยกว่า 3,000 บาท ( ) 2. 3,000 – 5,000 บาท

( ) 3. 5,001 – 8,000 บาท ( ) 4. 8,001 – 10,000 บาท

( ) 5. มากกว่า 10,000 บาทขึ้นไป

8. ท่านเคยมารับบริการที่ศูนย์สุขภาพชุมชน เขตเมือง หรือไม่

( ) เคย……..ครั้ง (ครั้งสุดท้ายเมื่อ.....)

( ) ไม่เคย (ข้ามไปตอบข้อ 10)

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9. เหตุจูงใจที่ทำให้ท่านมารับบริการที่แห่งนี้ คืออะไรบ้าง? (ตอบได้มากกว่า 1 คำตอบ)

( ) 1. จากคำบอกเล่าของญาติหรือผู้อื่นว่าที่นี่บริการดี

( ) 2. ตามความต้องการของตนเอง

( ) 3. จากการโฆษณาประชาสัมพันธ์

( ) 4. อยู่ใกล้บ้าน

( ) 5. สะดวกในการเดินทาง

( ) 6. มีโรคเรื้อรัง โรค .....

( ) 7. อื่นๆ ระบุ.....

ท่านคิดว่าข้อที่สำคัญที่สุดที่ทำให้ท่านมารับบริการที่ศูนย์สุขภาพชุมชน เขตเมือง โรงพยาบาลสระบุรี คือ ข้อ.....

10. เหตุผลที่ท่านไม่มารับบริการที่ ศูนย์สุขภาพชุมชน เขตเมือง โรงพยาบาลสระบุรี คือ .....

11. ท่านมี สิทธิในการรักษาพยาบาล ใดบ้าง?

( ) 1. บัตรทอง ( ) 5. ประกันชีวิต/ประกันสุขภาพ

( ) 2. ประกันสังคม ( ) 6. อื่นๆ ระบุ .....

( ) 3. เบิกได้/ข้าราชการ/รัฐวิสาหกิจ

( ) 4. สวัสดิการบริษัท

12. ระยะเวลาที่ท่านใช้ในการเดินทางจากบ้านถึง ศูนย์สุขภาพชุมชน เขตเมือง โรงพยาบาลสระบุรี ประมาณ.....นาที

13. ท่านได้รับข่าวสารประชาสัมพันธ์ด้านสุขภาพจากศูนย์สุขภาพชุมชน เขตเมือง โรงพยาบาลสระบุรี หรือไม่?

( ) 1. ไม่เคยได้รับ

( ) 2 เคยได้รับนานๆครั้ง

( ) 3 เคยได้รับบ่อยครั้ง เป็นประจำ

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ส่วนที่ 2 ความคาดหวังและการรับรู้บริการของประชาชน ตำบลปากเพรียว

<u>คำชี้แจง</u>

2.1 ความคาดหวังต่อบริการ

ในฐานะที่ท่านเคยใช้บริการการรักษาพยาบาลของศูนย์สุขภาพชุมชน เขตเมือง โรงพยาบาลสระบุรี ในความคิดเห็นของท่านที่มีต่อบริการของศูนย์สุขภาพชุมชน เขตเมือง โรงพยาบาลสระบุรี ท่านคิดว่าศูนย์สุขภาพชุมชนที่ดีตามที่ท่านคาดหวังไว้ว่าควรจะมีหรือควรจะเป็นศูนย์สุขภาพชุมชนที่มีคุณลักษณะและการให้บริการที่ดี ซึ่งจะกล่าวถึงในแต่ละข้อความต่อไปนี้มากน้อยเพียงใด

2.2 การรับรู้บริการภายหลังที่รับบริการแล้ว

ข้อความในรายการต่อไปนี้ เป็นการอธิบายถึงความรู้สึกของท่านที่มีต่อบริการของศูนย์สุขภาพชุมชน เขตเมือง โรงพยาบาลสระบุรีที่ท่านกำลังรับบริการรักษาพยาบาลอยู่ในขณะนี้ โดยที่ท่านคิดว่าบริการที่ได้รับนั้นเป็นจริงตามความรู้สึกของท่าน ซึ่งศูนย์สุขภาพชุมชน เขตเมือง โรงพยาบาลสระบุรีแห่งนี้มีคุณลักษณะและการบริการดังที่อธิบายไว้ในข้อความดังที่จะกล่าวถึงต่อไปนี้

<u>ขอให้ท่านโปรดบอกหมายเลขเพียงหมายเลขเดียวเท่านั้น โดยแต่ละหมายเลขมีความหมายดังนี้</u>

หมายเลข 1 หมายถึง ท่านไม่เห็นด้วยอย่างยิ่ง
หมายเลข 2 หมายถึง ท่านไม่เห็นด้วยอย่างมาก
หมายเลข 3 หมายถึง ท่านไม่เห็นด้วยค่อนข้างมาก
หมายเลข 4 หมายถึง ท่านเห็นปานกลาง
หมายเลข 5 หมายถึง ท่านเห็นด้วยค่อนข้างมาก
หมายเลข 6 หมายถึง ท่านเห็นด้วยอย่างมาก
หมายเลข 7 หมายถึง ท่านเห็นด้วยอย่างยิ่ง

คำตอบของท่านไม่มีถูกหรือผิด โปรดตอบให้ครบทุกข้อ และขอให้ท่านตอบตามที่ท่านเห็นว่าเป็นจริงที่สุด

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		ไม่เห็นด้วยอย่างยิ่ง						เห็นด้วยอย่างยิ่ง	ไม่เห็นด้วยอย่างยิ่ง						เห็นด้วยอย่างยิ่ง
		1	2	3	4	5	6	7	1	2	3	4	5	6	7
1.	ศูนย์สุขภาพชุมชน ควรที่จะ มีป้ายหรือเครื่องหมายบอกห้องต่างๆที่ อ่านง่าย และมองเห็นชัดเจน	1	2	3	4	5	6	7	1	2	3	4	5	6	7
2.	อาคารสถานที่ของหน่วยงานบริการศูนย์สุขภาพชุมชน ควรสะอาด และดูสบายตา	1	2	3	4	5	6	7	1	2	3	4	5	6	7
3.	ห้องฉีดยา/ทำแผล ห้องบัตร ห้องยา ห้องจ่ายเงิน ห้องเจาะเลือด ห้องทันตกรรม ควร อยู่ในบริเวณเดียวกันหรืออยู่ใกล้กันเพื่อสะดวกต่อการบริการ	1	2	3	4	5	6	7	1	2	3	4	5	6	7
4.	เครื่องมือและอุปกรณ์ของศูนย์สุขภาพชุมชน ควรมีครบถ้วนและเพียงพอ	1	2	3	4	5	6	7	1	2	3	4	5	6	7
5.	ศูนย์สุขภาพชุมชนควรมี ตู้น้ำดื่ม หนังสือพิมพ์ โทรทัศน์และแผ่นพับให้ความรู้ด้านสุขภาพ มีเพียงพอและน่าสนใจ	1	2	3	4	5	6	7	1	2	3	4	5	6	7
6.	อุปกรณ์เครื่องมือเครื่องใช้ในการบริการของศูนย์สุขภาพชุมชน พร้อมมูลและสามารถใช้ได้ทันที	1	2	3	4	5	6	7	1	2	3	4	5	6	7
7.	เจ้าหน้าที่ควรให้การต้อนรับท่านด้วยอัธยาศัย ไมตรีที่ดี	1	2	3	4	5	6	7	1	2	3	4	5	6	7
8.	เจ้าหน้าที่ควรมีท่าทางยิ้มแย้มแจ่มใส พูดจาไพเราะและ แต่งกายสะอาดเรียบร้อย	1	2	3	4	5	6	7	1	2	3	4	5	6	7

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		1	**2**	**3**	**4**	**5**	**6**	**7**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
9.	การบริการผู้ป่วยที่ศูนย์สุขภาพชุมชน มีเจ้าหน้าที่ผู้ที่คอยช่วยเหลือและให้ข้อมูลข่าวสารตามที่ท่านต้องการ	1	2	3	4	5	6	7	1	2	3	4	5	6	7
10.	เมื่อผู้ป่วยมาถึงศูนย์สุขภาพชุมชน พยาบาล ควร สามารถประเมินสภาพของผู้ป่วย และสามารถให้การดูแลช่วยเหลือขั้นต้นแก่ผู้ที่มีอาการเจ็บป่วยมาก	1	2	3	4	5	6	7	1	2	3	4	5	6	7
11.	แพทย์ และพยาบาล รวมทั้งผู้ให้บริการในศูนย์สุขภาพชุมชนควรเป็นทีมประจำในแต่ละวัน	1	2	3	4	5	6	7	1	2	3	4	5	6	7
12.	แพทย์ ควรอธิบายเกี่ยวกับโรคและแนวทางในการดูแลรักษาอย่าง สอดคล้องกับอาการเจ็บป่วยของท่านโดยชัดเจนและเข้าใจง่าย	1	2	3	4	5	6	7	1	2	3	4	5	6	7
13.	แพทย์ที่ตรวจรักษาท่านควรเป็นผู้ที่มีความเชี่ยวชาญและเหมาะสมในการเป็นแพทย์ประจำครอบครัวของท่าน (รู้และเข้าใจในด้านร่างกาย จิตใจ สังคม วัฒนธรรมและเศรษฐกิจของท่าน)	1	2	3	4	5	6	7	1	2	3	4	5	6	7
14.	แพทย์ควรสนใจฟังคำบอกเล่าเกี่ยวกับอาการเจ็บป่วยของท่าน	1	2	3	4	5	6	7	1	2	3	4	5	6	7
15.	แพทย์ควรซักประวัติและตรวจสภาพร่างกายของท่านอย่าง	1	2	3	4	5	6	7	1	2	3	4	5	6	7

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		1	2	3	4	5	6	7	1	2	3	4	5	6	7
	ละเอียด														
16.	แพทย์ พยาบาลและทีมที่ให้บริการด้านสุขภาพแก่ท่าน ควรให้บริการสุขภาพที่ต่อเนื่องแก่ครอบครัว และชุมชน ของท่าน	1	2	3	4	5	6	7	1	2	3	4	5	6	7
17.	พยาบาลควรอธิบายเกี่ยวกับการรักษาพยาบาลให้ท่านเข้าใจจนเกิดความไว้วางใจในการรักษาที่ได้รับว่าถูกต้องเหมาะสม	1	2	3	4	5	6	7	1	2	3	4	5	6	7
18.	เจ้าหน้าที่ควรสามารถแก้ไขปัญหา/ช่วยเหลือและให้คำแนะนำแก่ท่านได้ตามที่ท่านร้องขอ	1	2	3	4	5	6	7	1	2	3	4	5	6	7
19.	เจ้าหน้าที่ผู้นั้นควรสามารถตอบข้อซักถามของท่านได้อย่างชัดเจนและหายสงสัย	1	2	3	4	5	6	7	1	2	3	4	5	6	7
20.	เจ้าหน้าที่ควรให้คำแนะนำแก่ท่าน ทั้งทางด้านส่งเสริมสุขภาพ การป้องกันโรค การรักษาพยาบาลและการฟื้นฟูสภาพ โดยคำนึงถึงปัจจัยทางด้านร่างกาย จิตใจ สังคมและเศรษฐกิจของท่าน	1	2	3	4	5	6	7	1	2	3	4	5	6	7
21.	เจ้าหน้าที่ควรแจ้งกำหนดเวลาในการให้บริการที่แน่นอนแก่ผู้ป่วยและญาติ	1	2	3	4	5	6	7	1	2	3	4	5	6	7
22.	เจ้าหน้าที่ควรแสดงความเต็มใจในการดูแลช่วยเหลือท่าน	1	2	3	4	5	6	7	1	2	3	4	5	6	7

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		1	2	3	4	5	6	7	1	2	3	4	5	6	7
23.	เจ้าหน้าที่ควรตั้งใจรับฟังเรื่องราวที่ท่านบอกเล่า ระบายความทุกข์หรือความไม่สบายใจเกี่ยวกับอาการเจ็บป่วยให้ฟัง	1	2	3	4	5	6	7	1	2	3	4	5	6	7
24.	เจ้าหน้าที่ควรแสดงความเห็นอกเห็นใจในอาการเจ็บป่วยของท่าน														
25.	เจ้าหน้าที่ ควรทราบและเข้าใจความต้องการด้านสุขภาพของท่านเป็นอย่างดี														
26.	เจ้าหน้าที่ ควรเข้าใจความรู้สึกของแต่ละคนในการต้องการรับบริการว่ามีความจำเป็นเร่งด่วนแตกต่างกัน														
27.	เมื่อท่านมีปัญหาเกี่ยวกับค่าตรวจรักษาหรือค่ายา เจ้าหน้าที่สามารถให้การ ช่วยเหลือและแก้ปัญหาให้ท่านได้														
28.	ท่านควรได้รับบริการเท่าเทียมกับคนอื่นๆ														
29.	ท่านควรได้รับบริการที่ดีในทุกจุดที่ให้บริการ														
30.	เมื่อท่านมาตรวจรักษา ท่านมีความรู้สึกว่าได้รับการตรวจรักษาโรคหรือการตรวจเพื่อหาสาเหตุของโรค รวมทั้งได้รับการส่งต่อไปยังหน่วยบริการอื่นๆที่จำเป็น อย่างถูกต้องเหมาะสม														

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ส่วนที่ 3 ปัญหา อุปสรรคและข้อเสนอแนะในการบริการของศูนย์สุขภาพชุมชน เขตเมือง โรงพยาบาลสระบุรี

<u>คำชี้แจง</u>

กรุณาระบุปัญหา อุปสรรคที่ท่านพบในการมารับบริการที่ศูนย์สุขภาพชุมชน เขตเมือง โรงพยาบาลสระบุรี พร้อมทั้งให้ข้อเสนอแนะเพื่อการปรับปรุงให้ดีขึ้น โดยทำเครื่องหมาย✓หน้าข้อที่ท่านเลือก

1. ท่านมีปัญหาในการรับบริการจากศูนย์สุขภาพชุมชน เขตเมือง โรงพยาบาลสระบุรี ในประเด็นต่อไปนี้หรือไม่?

	ไม่มี	มี ระบุ
1.1 การประชาสัมพันธ์	( )	( ) .....
1.2 การเดินทางมาศูนย์สุขภาพชุมชน	( )	( ) .....
1.3 การจัดสถานที่ของศูนย์	( )	( ) .....
1.4 การให้บริการเมื่อมาถึง	( )	( ) .....
1.5 ที่จอดรถ	( )	( ) .....
1.6 ห้องบัตร	( )	( ) .....
1.7 ห้องรอตรวจ	( )	( ) .....
1.8 ห้องน้ำ	( )	( ) .....
1.9 การตรวจจากแพทย์	( )	( ) .....
1.10 การตรวจเลือด/ทำแผล/ฉีดยา	( )	( ) .....
1.11 การนัดฟังผลการตรวจต่างๆ	( )	( ) .....
1.12 การจ่ายยา	( )	( ) .....
1.13 การให้คำแนะนำก่อนกลับบ้าน	( )	( ) .....
1.14 การให้ความช่วยเหลือในการเดินทางกลับ	( )	( ) .....
1.15 การเยี่ยมบ้าน	( )	( ) .....
1.16 อื่นๆระบุ	( )	( ) .....

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คะแนนเฉลี่ย
และส่วนเบี่ยงเบนมาตรฐานของข้อคำถาม

ตารางผนวกที่ 1 คะแนนเฉลี่ย และส่วนเบี่ยงเบนมาตรฐานของ**ความคาดหวัง**เกี่ยวกับคุณภาพบริการ จำแนกเป็นรายข้อ

ด้านความเป็นรูปธรรมของบริการ

ข้อที่	ข้อความ	$\bar{X}$	SD
1.	ศูนย์สุขภาพชุมชน ควรที่จะมีป้าย หรือเครื่องหมายบอกห้องต่างๆ ที่อ่านง่าย และมองเห็นชัดเจน	6.84	0.49
2.	อาคารสถานที่ของศูนย์สุขภาพชุมชน ควรสะอาด และดูสบายตา	6.83	0.52
3.	ห้องฉีดยา/ ทำแผล ห้องบัตร ห้องยา ห้องจ่ายเงิน ห้องเจาะเลือด ห้องทันตกรรม ควรอยู่ในบริเวณเดียวกัน หรืออยู่ใกล้กัน เพื่อสะดวกต่อการรับบริการ	6.83	0.48
4.	เครื่องมือ และอุปกรณ์ของศูนย์สุขภาพชุมชน ควรมีครบถ้วน และเพียงพอ	6.82	0.49
5.	ศูนย์สุขภาพชุมชนควรมีตู้น้ำดื่ม หนังสือพิมพ์ โทรทัศน์ และแผ่นพับ ให้ความรู้ด้านสุขภาพ มีเพียงพอและน่าสนใจ	6.80	0.57
8.	เจ้าหน้าที่ ควรมีท่าทางยิ้มแย้มแจ่มใส พูดจาไพเราะ และแต่งกายสะอาด เรียบร้อย	6.92	0.31
11.	แพทย์ และพยาบาล รวมทั้งผู้ให้บริการในศูนย์สุขภาพชุมชน ควรเป็นทีมประจำในแต่ละวัน	6.84	0.53
	รวม	**6.84**	**0.37**

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ด้านความเชื่อถือและไว้วางใจได้

ข้อที่	ข้อความ	$\bar{X}$	SD
6.	อุปกรณ์ เครื่องมือเครื่องใช้ในการบริการของศูนย์สุขภาพชุมชน พร้อมมูล และสามารถใช้ได้ทันที	6.85	0.50
13.	แพทย์ที่ตรวจรักษาท่าน ควรเป็นผู้ที่มีความเชี่ยวชาญ และเหมาะสมในการเป็นแพทย์ประจำครอบครัวของท่าน (รู้ และเข้าใจในด้านร่างกาย จิตใจ สังคม วัฒนธรรม และเศรษฐกิจของท่าน)	6.83	0.57
15.	แพทย์ ควรซักประวัติ และตรวจร่างกายของท่านอย่างละเอียด	6.87	0.45
17.	พยาบาลควรอธิบายเกี่ยวกับการรักษาพยาบาลให้ท่านข้าใจ จนเกิดความไว้วางใจในการรักษาที่ได้รับว่า ถูกต้อง เหมาะสม	6.84	0.50
18.	เจ้าหน้าที่ ควรสามารถแก้ไขปัญหา ช่วยเหลือ และให้คำแนะนำแก่ท่านได้ ตามที่ท่านร้องขอ	6.84	0.49
	รวม	**6.85**	**0.42**

ด้านการตอบสนองต่อผู้รับบริการ

ข้อที่	ข้อความ	$\bar{X}$	SD
7.	เจ้าหน้าที่ ควรให้การต้อนรับท่านด้วยอัธยาศัย ไมตรี	**6.89**	0.43
9.	การบริการผู้ป่วยที่ศูนย์สุขภาพชุมชน มีเจ้าหน้าที่ผู้ที่คอยช่วยเหลือและให้ข้อมูลข่าวสารตามที่ท่านต้องการ	6.86	0.48
14.	แพทย์ควรสนใจคำบอกเล่าเกี่ยวกับอาการเจ็บป่วยของท่าน	6.86	0.41
20.	เจ้าหน้าที่ควรให้คำแนะนำแก่ท่าน ทั้งทางด้านส่งเสริมสุขภาพ การป้องกันโรค การรักษาพยาบาล และการฟื้นฟูสุขภาพ โดยคำนึงถึงปัจจัยทางด้านร่างกาย จิตใจ สังคม และเศรษฐกิจของท่าน	6.80	0.58
21.	เจ้าหน้าที่ควรแจ้งกำหนดเวลาในการให้บริการที่แน่นอนแก่ผู้ป่วยและญาติ	6.87	0.46
22.	เจ้าหน้าที่ควรแสดงความเต็มใจในการดูแลช่วยเหลือท่าน	6.82	0.56
	รวม	**6.85**	**0.42**

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ด้านการให้ความมั่นใจแก่ผู้รับบริการ

ข้อที่	ข้อความ	$\bar{X}$	SD
10.	เมื่อผู้ป่วยมาถึงศูนย์สุขภาพชุมชน พยาบาล ควรสามารถประเมินสภาพของผู้ป่วย และสามารถให้การดูแลช่วยเหลือขั้นต้นแก่ผู้ที่มีอาการเจ็บป่วยมาก	6.81	0.52
12.	แพทย์ควรอธิบายเกี่ยวกับโรค และแนวทางในการดูแลรักษาอย่างสอดคล้องกับอาการเจ็บป่วยของท่าน โดยชัดเจนและเข้าใจง่าย	6.86	0.41
16.	แพทย์ พยาบาล และทีมที่ให้บริการด้านสุขภาพแก่ท่าน ควรให้บริการสุขภาพที่ต่อเนื่องแก่ครอบครัว และชุมชนของท่าน	6.85	0.44
19.	เจ้าหน้าที่ผู้นั้น ควรสามารถตอบข้อซักถามของท่านได้อย่างชัดเจนและหายสงสัย	6.83	0.51
29.	ท่านควรได้รับการบริการที่ดี ในทุกจุดที่ให้บริการ	6.89	0.41
30.	เมื่อท่านมาตรวจรักษา ท่านมีความรู้สึกว่าได้รับการตรวจรักษาโรคหรือการตรวจเพื่อหาสาเหตุของโรค รวมทั้งได้รับการส่งต่อไปยังหน่วยบริการอื่นๆ ที่ จำเป็นอย่างถูกต้องเหมาะสม	6.90	0.40
	รวม	**6.86**	**0.39**

ด้านความเข้าใจและเห็นอกเห็นใจในผู้รับบริการ

ข้อที่	ข้อความ	$\bar{X}$	SD
23.	เจ้าหน้าที่ควรตั้งใจรับฟังเรื่องราวที่ท่านบอกเล่า ระบายความทุกข์หรือความ ไม่สบายใจเกี่ยวกับอาการเจ็บป่วยให้ฟัง	6.78	0.63
24.	เจ้าหน้าที่ควรแสดงความเห็นอกเห็นใจในอาการเจ็บป่วยของท่าน	6.74	0.73
25.	เจ้าหน้าที่ควรทราบ และเข้าใจความต้องการด้านสุขภาพของท่านเป็นอย่างดี	6.80	0.62
26.	เจ้าหน้าที่ควรเข้าใจความรู้สึกของแต่ละคนในการต้องการรับบริการว่ามีความ จำเป็น เร่งด่วนแตกต่างกัน	6.77	0.65
27.	เมื่อท่านมีปัญหาเกี่ยวกับค่ารักษา หรือค่ายา เจ้าหน้าที่สามารถให้การช่วยเหลือ และแก้ปัญหาให้ท่านได้	6.81	0.55
28.	ท่านควรได้รับการบริการเท่าเทียมกับคนอื่นๆ	6.89	0.41
	รวม	**6.80**	**0.54**

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ตารางผนวกที่ 2 คะแนนเฉลี่ย และส่วนเบี่ยงเบนมาตรฐานของการรับรู้เกี่ยวกับคุณภาพบริการ จำแนกเป็นรายข้อ

ด้านความเป็นรูปธรรมของบริการ

ข้อที่	ข้อความ	$\bar{X}$	SD
1.	ศูนย์สุขภาพชุมชน มีป้ายหรือเครื่องหมายบอกห้องต่างๆ ที่อ่านง่าย และมองเห็นชัดเจน	5.34	0.99
2.	อาคารสถานที่ของศูนย์สุขภาพชุมชนสะอาด และดูสบายตา	5.47	1.10
3.	ห้องฉีดยา/ ทำแผล ห้องบัตร ห้องยา ห้องจ่ายเงิน ห้องเจาะเลือด ห้องทันตกรรม อยู่ในบริเวณเดียวกัน หรืออยู่ใกล้กัน เพื่อสะดวกต่อการบริการ	5.31	0.99
4.	เครื่องมือ และอุปกรณ์ของศูนย์สุขภาพชุมชน มีครบถ้วน และเพียงพอ	5.26	1.00
5.	ศูนย์สุขภาพชุมชนมีตู้น้ำดื่ม หนังสือพิมพ์ โทรทัศน์ และแผ่นพับ ให้ความรู้ด้านสุขภาพ มีเพียงพอและน่าสนใจ	**5.13**	1.06
8.	เจ้าหน้าที่มีท่าทางยิ้มแย้มแจ่มใส พูดจาไพเราะ และแต่งกายสะอาดเรียบร้อย	5.68	0.95
11.	แพทย์ และพยาบาล รวมทั้งผู้ให้บริการในศูนย์สุขภาพชุมชน เป็นทีมประจำในแต่ละวัน	5.68	1.00
	รวม	**5.41**	**0.76**

ด้านความเชื่อถือและไว้วางใจได้

ข้อที่	ข้อความ	$\bar{X}$	SD
6.	อุปกรณ์ เครื่องมือเครื่องใช้ในการบริการของศูนย์สุขภาพชุมชน พร้อมมูล และสามารถใช้ได้ทันที	**5.33**	0.94
13.	แพทย์ที่ตรวจรักษา เป็นผู้ที่มีความเชี่ยวชาญ และเหมาะสมในการเป็นแพทย์ประจำครอบครัวท่าน (รู้ และเข้าใจในด้านร่างกาย จิตใจ สังคม วัฒนธรรม และเศรษฐกิจของท่าน)	5.67	1.05
15.	แพทย์ซักประวัติและตรวจร่างกายของท่านอย่างละเอียด	5.85	0.96
17.	พยาบาลอธิบายเกี่ยวกับการรักษาพยาบาลให้ท่านข้าใจ จนเกิดความไว้วางใจในการรักษาที่ได้รับว่า ถูกต้อง เหมาะสม	5.44	0.91
18.	เจ้าหน้าที่สามารถแก้ไขปัญหา ช่วยเหลือ และให้คำแนะนำแก่ท่านได้ ตามที่ท่านร้องขอ	5.35	0.91
	รวม	**5.53**	**0.73**

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ด้านการตอบสนองต่อผู้รับบริการ

ข้อที่	ข้อความ	$\bar{X}$	SD
7.	เจ้าหน้าที่ให้การต้อนรับท่านด้วยอัธยาศัย ไมตรีที่ดี	5.64	0.92
9.	การบริการผู้ป่วยที่ศูนย์สุขภาพชุมชน มีเจ้าหน้าที่ผู้ที่คอยช่วยเหลือและให้ข้อมูลข่าวสารตามที่ท่านต้องการ	5.37	0.85
14.	แพทย์สนใจคำบอกเล่าเกี่ยวกับอาการเจ็บป่วยของท่าน	5.82	0.93
20.	เจ้าหน้าที่ให้คำแนะนำแก่ท่าน ทั้งทางด้านส่งเสริมสุขภาพ การป้องกันโรค การรักษาพยาบาล และการฟื้นฟูสุขภาพ โดยคำนึงถึงปัจจัยทางด้านร่างกาย จิตใจ สังคม และเศรษฐกิจของท่าน	5.26	0.74
21.	เจ้าหน้าที่แจ้งกำหนดเวลาในการให้บริการที่แน่นอนแก่ผู้ป่วยและญาติ	5.58	0.97
22.	เจ้าหน้าที่แสดงความเต็มใจในการดูแลช่วยเหลือท่าน	5.55	0.95
	รวม	**5.54**	**0.68**

ด้านการให้ความมั่นใจแก่ผู้รับบริการ

ข้อที่	ข้อความ	$\bar{X}$	SD
10.	เมื่อผู้ป่วยมาถึงศูนย์สุขภาพชุมชน พยาบาลสามารถประเมินสภาพของผู้ป่วย และสามารถให้การดูแลช่วยเหลือขั้นต้นแก่ผู้ที่มีอาการเจ็บป่วยมาก	5.25	0.84
12.	แพทย์อธิบายเกี่ยวกับโรค และแนวทางในการดูแลรักษาอย่างสอดคล้องกับอาการเจ็บป่วยของท่าน โดยชัดเจนและเข้าใจง่าย	5.63	0.89
16.	แพทย์ พยาบาล และทีมที่ให้บริการด้านสุขภาพแก่ท่าน ให้บริการสุขภาพที่ต่อเนื่องแก่ครอบครัว และชุมชนของท่าน	5.60	0.91
19.	เจ้าหน้าที่ผู้นั้นสามารถตอบข้อซักถามของท่านได้อย่างชัดเจน และหายสงสัย	5.38	0.81
29.	ท่านได้รับการบริการที่ดี ในทุกจุดที่ให้บริการ	5.52	1.06
30.	เมื่อท่านมาตรวจรักษา ท่านมีความรู้สึกว่าได้รับการตรวจรักษาโรค หรือการตรวจเพื่อหาสาเหตุของโรค รวมทั้งได้รับการส่งต่อไปยังหน่วยบริการอื่นๆ ที่ จำเป็นอย่างถูกต้องเหมาะสม	5.50	1.10
	รวม	**5.48**	**0.74**

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ด้านความเข้าใจและเห็นอกเห็นใจในผู้รับบริการ

ข้อที่	ข้อความ	$\bar{X}$	SD
23.	เจ้าหน้าที่ตั้งใจรับฟังเรื่องราวที่ท่านบอกเล่า ระบายความทุกข์ หรือความไม่สบายใจเกี่ยวกับอาการเจ็บป่วยให้ฟัง	5.33	0.95
24.	เจ้าหน้าที่แสดงความเห็นอกเห็นใจในอาการเจ็บป่วยของท่าน	5.40	0.90
25.	เจ้าหน้าที่ทราบ และเข้าใจความต้องการด้านสุขภาพของท่านเป็นอย่างดี	5.37	0.95
26.	เจ้าหน้าที่เข้าใจความรู้สึกของแต่ละคนในการต้องการรับบริการว่ามีความจำเป็น เร่งด่วนแตกต่างกัน	**5.30**	1.00
27.	เมื่อท่านมีปัญหาเกี่ยวกับค่าตรวจรักษา หรือค่ายา เจ้าหน้าที่สามารถให้การ ช่วยเหลือ และแก้ปัญหาให้ท่านได้	5.35	0.86
28.	ท่านได้รับการบริการเท่าเทียมกับคนอื่นๆ	5.62	1.00
	รวม	**5.40**	**0.77**

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BIOGRAPHY

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INSTITUTIONS ATTENDED	Faculty of Nursing, Mahidol University 1986-1990. Faculty of Public Health Administration Major in Hospital Administration Mahidol University 2000-2007.
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