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# Organizational commitment, patient satisfaction and loyalty in the first-level health facilities

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**ABSTRACT**

Patient satisfaction and loyalty are widely cited as markers of healthcare quality. Organizational commitment assists first-level health facilities in achieving the goals by incorporating physicians in the implementation of holistic and comprehensive care. This study aims to analyze a structural model of physician organizational commitment, patient satisfaction, and loyalty in first-level health facilities. This study used an explanatory research design with a total sample of 199 physicians and 980 patients in 30 public and private first-level health facilities within the collaboration of national healthcare and social security, chosen by systematic random sampling. Analysis was performed by using partial least squares–structural equation modeling (PLS-SEM). Physician factors, organizational factors, and non-organizational factors have the strongest influence on physician organizational commitment (80.2%). To sum up, major efforts should be made to improve organizational commitment among physicians in providing holistic and comprehensive care in first-level health facilities to boost patient satisfaction and loyalty.



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## 1. INTRODUCTION

Recent advances in health care reform have changed to improving health service quality and safety in health care. Health care facilities that provide medical services are becoming more competitive, therefore they must constantly enhance their service quality. This can only be achieved if health service providers gain a better understanding of service quality from the standpoint of patients. In determining the quality of services given, the interaction between the health service provider and the patient is critical [1], [2]. Hospital competition has also a positive impact on the delivery of healthcare services. Meeting the needs and expectations of patients could help to improve high-quality services. Having high-quality medical personnel is one of the most important factors in improving care quality through continuing education and providing long-term rewards for outstanding medical staff [3].

Patient satisfaction and loyalty are frequently used as indicators to assess the quality of health-care services. Studies showed that private health care facilities are attempting to deliver higher-quality services and play a positive role in attracting and retaining patients [1], [2]. In light of a fact that a loyal patient would always spread positive word of mouth and become an organization's most honest resource for determining profitability and authority [1], [2]. From this perspective, health care facilities should strive to deliver the best medical care and services tailored to individual patients to encourage repeat visits, either to public or private

first-level health facilities. Even during the COVID-19 pandemic, health-care providers' response times are improving, reducing COVID-19 infection spread. Furthermore, people who visit first-level health facilities believe that health workers are more active in explaining or assisting patients with their illnesses [4].

Organizational commitment is a product of individual behavior, and the willingness to make efforts overtime for the organization. It concerns sentiments of attachment to the organization's objectives and principles, its part in this, and its attachment, for its own sake instead of its exclusively instrumental value, to the organization. Organizational commitment aids first-level health facility management in achieving goals by including physicians in the implementation of holistic and comprehensive treatment. The proportional strength of an individual's identification and involvement in a particular organization is referred to as organizational commitment [5]. Additionally, commitment to the organization is essential for individual long-term success. Health care providers' factors, job experience, work setting, and organizational characteristics have all been found to be predictive of organizational commitment in the previous study [6].

In addition, employee commitment is regarded as a measure of alignment between employee motivation and organizational goals. It is assumed that the greater the degree of alignment between employee motivation and organizational mission, the greater the employee's stake in the organization's success and the greater the employee's desire to provide exemplary service to patients. The previous study has looked into the relationship between employee commitment, particularly affective commitment, and patient satisfaction. They also discovered that when services are delivered by a dedicated workforce, patients perceive higher service quality [7]. This emphasizes the importance of healthcare decision-makers considering employee commitment as a competitive variable, which is frequently overlooked in strategic plans.

Patient satisfaction assesses the perceived quality of care and serves as a means of providing feedback to healthcare providers on a variety aspect of health care [8]. The fact that patient satisfaction predicts health provider choice suggests a path by which people naturally gravitate toward higher-quality care, despite the difficulties in assessing service quality. Satisfied patients are also more likely to follow through on recommended treatment and are less likely to file a malpractice claim.

Patient loyalty is defined as a strong desire to repurchase a desired service in the future. Further, other aspects of the health facilities also have an impact on patient loyalty. Taking everything else into account, public health facilities have lower patient loyalty than their private counterparts. Patients are also less likely to return to a health facility when there are only several alternatives or no other choices [9]. Previous research has even explained several factors that influence patient satisfaction, including perceived value, confidence, and quality [10]. However, the discussion of organizational and non-organizational factors has not been widely discussed.

Physicians will be able to establish a more thorough patient assessment with the support of a holistic-comprehensive approach. Furthermore, physicians must investigate novel health-care delivery models that go beyond their current area of practice. Holistic-comprehensive approaches can be used as new ways to identify factors that may be related to patient health, especially in first-level health facilities [11].

Organizational commitment, patient satisfaction, and patient loyalty are all substantially associated, according to empirical studies. In light of our current circumstances, more focus should be placed on developing a model of organizational commitment, particularly in first-level health facilities, where researchers will uncover and develop real-world answers to challenges. More research is needed to better understand the elements that influence organizational commitment, patient happiness, and loyalty at first-level health facilities that collaborate with national healthcare and social security. This study aims to analyze a structural model of organizational commitment, patient satisfaction, and loyalty in first-level health facilities.

In this study, several hypotheses are taken into account: Hypothesis 1 (H1): Physician factors, organizational and non-organizational factors affect physician organizational commitment in implementing holistic and comprehensive care; Hypothesis 2 (H2): Physician organizational commitment in implementing holistic and comprehensive care affect patient satisfaction; Hypothesis 3 (H3): Patient satisfaction affect patient loyalty; Hypothesis 4 (H4): Patient factors affect patient satisfaction; Hypothesis 5 (H5): Patient factors influence the effect of physician organizational commitment on patient satisfaction, and Hypothesis 6 (H6): Patient factors influence the effect of patient satisfaction on patient loyalty.

## 2. RESEARCH METHOD

This study used an explanatory research design with a total sample of 199 physicians and 980 patients in 30 public and private first-level health facilities within the collaboration of national healthcare and social security. Systematic random sampling was chosen by selecting respondents across the health facilities at a set of intervals. For the data set, the observed information includes the highest number of patient visits at both public and private first-level health facilities.

Sampling was carried out at the time of the highest number of patient visits based on the results of data observations, then the assumption of the number of patients at that time was divided by 30 to determine

the selected sample interval. There are two groups of respondents involved in the study: i) Physician who provides services at least three months in the first-level health facilities (public and private first-level health facilities within the collaboration of national healthcare and social security); and ii) Patient who is covered under national healthcare and social security. Respondents whose characteristics did not meet the requirement of the study are excluded from the study: i) Physician who work as substitute health professionals in the first-level health facilities; ii) Patient who is diagnosed with mental disorder, deafness, or speech disorder. Ethical approval of the study was obtained from the Ethics Committee of Faculty Medicine, Universitas Muhammadiyah Malang (No. E.5.a/060/KEPK-UMM/III/2019). All respondents gave their permission to be part of this study and they also have the right to refuse to participate without penalty.

The data set using an electronic self-administered questionnaires included 24 indicators that were designed to explain the exogenous variables: organizational commitment, physician factors, organizational factors, non-organizational factors, and the endogenous variables: patient satisfaction, patient loyalty. The moderating variable that affects the strength of the relationship between the exogenous and endogenous variables is patient factors. All indicators in each variable are explained in Table 1. Analysis was performed by using partial least squares–structural equation modeling (PLS-SEM) to evaluate the theoretical model. Table 2 demonstrates that all instruments are valid and reliable. Pearson's correlation was used to assess construct validity at a 5% significance level and to confirm the strength of the existing linear association between variables. Furthermore, reliability was confirmed by a Cronbach's Alpha coefficient greater than 0.6. The theoretical path model for this study was created by determining variables related to organizational commitment, patient satisfaction, and patient loyalty from various types of literature as shown in Figure 1.

Table 1. Indicators for reflective measurement model constructs

| Indicators | Definition |
|---|---|
| Organizational commitment | |
| Affective commitment (X1a) | Physician emotional attachment to first-level health facilities |
| Continuance commitment (X1b) | Physician attachment to first-level health facilities based on the personal benefits and needs fulfillment |
| Normative commitment (X1c) | Physician attachment to first-level health facilities is based on the obligations and responsibilities that must be carried out |
| Physician factors | |
| Sex (X1.1a) | Physician characteristics based on sex |
| Age (X1.1b) | Physician characteristics based on age |
| Years of professional experiences (X1.1c) | The number of years has been registered as physician |
| Duration of employment in first-level health facilities (X1.1d) | The number of years physician worked in first-level health facilities |
| Employment status (X1.1e) | The status of physician engaged to work in first-level health facilities |
| Training of holistic and comprehensive care (X1.1f) | Medical training provided for physician working in first-level health facilities related to the physical, psychological, and social needs of the patient |
| Training of national healthcare and social security program (X1.1g) | Medical training provided for physician working associated with national healthcare and social security programs in first-level health facilities |
| Organizational factors | |
| Mission, vision and values statements (X1.2a) | Mission, vision, and values statements of first-level health facilities |
| Health service standards (X1.2b) | Standard treatment guidelines that must be understood by physician in providing health services to patients |
| Reward system (X1.2c) | Awards are given by the first-level health facilities to physician |
| Non-organizational factors | |
| Health policy of national healthcare and social security (X1.3a) | Regulations issued by national healthcare and social security as guidelines for providing care in the first-level health facilities |
| Job opportunities (X1.3b) | Job opportunities available outside first-level health facilities |
| Patient factors | |
| Word of mouth (X2a) | Patient's utilization of first-level health facilities based on information from other people who have used the facilities |
| Patient initiatives (X2b) | Patient accessing first-level health facilities based on their own initiatives |
| Previous experiences (X2c) | First-level health facilities utilization based on past experiences |
| Patient satisfaction | |
| Physical aspects (Y1a) | Management of health problems based on physical factors |
| Mental health aspects (Y1b) | Providing emotional support to patients |
| Social aspects (Y1c) | Integrating social care that impacts patients' health |
| Patient loyalty | |
| Using health facilities with similar cases (Y2a) | Patient behavior to reuse health services with the similar health issues |
| Using health facilities with different cases (Y2b) | Patient behavior to reuse health services with different health issues from the past |
| Society recommendations (Y2c) | Patient behavior to provide positive information about health services and recommend it to others |

Table 2. Validity and reliability of the research instruments

| Constructs | Item | Validity | Cronbach's Alpha |
|---|---|---|---|
| **Organizational commitment** | | | |
| Affective commitment | A1 | 0.877 | |
| | A2 | 0.754 | 0.715 |
| | A3 | 0.760 | |
| Continuance commitment | A4 | 0.880 | |
| | A5 | 0.752 | 0.800 |
| | A6 | 0.925 | |
| Normative commitment | A7 | 0.849 | |
| | A8 | 0.774 | 0.695 |
| | A9 | 0.765 | |
| **Organizational factors** | | | |
| Health service standards | B1 | 0.983 | |
| | B2 | 0.983 | 0.967 |
| | B3 | 0.942 | |
| *Reward system* | B4 | 0.944 | |
| | B5 | 0.823 | 0.824 |
| | B6 | 0.840 | |
| **Non organizational factors** | | | |
| Health policy of national healthcare and social security | B1a | 0.964 | |
| | B2a | 0.902 | 0.933 |
| | B3a | 0.975 | |
| Job opportunities | B4a | 0.909 | |
| | B5a | 0.953 | 0.933 |
| | B6a | 0.958 | |
| **Patient satisfaction** | | | |
| Biological aspect | C1 | 0.986 | |
| | C2 | 0.959 | 0.979 |
| | C3 | 0.977 | |
| | C4 | 0.958 | |
| Psychological aspect | C5 | 0.994 | |
| | C6 | 0.985 | 0.987 |
| | C7 | 0.973 | |
| | C8 | 0.977 | |
| Social aspect | C9 | 0.631 | |
| | C10 | 0.826 | 0.819 |
| | C11 | 0.889 | |
| | C12 | 0.855 | |
| **Loyalty** | | | |
| Similar cases | D1 | 0.900 | |
| | D2 | 0.856 | 0.766 |
| | D3 | 0.722 | |
| Different cases | D4 | 0.859 | |
| | D5 | 0.833 | 0.831 |
| | D6 | 0.901 | |
| Recommendations | D7 | 0.862 | |
| | D8 | 0.651 | 0.718 |
| | D9 | 0.885 | |

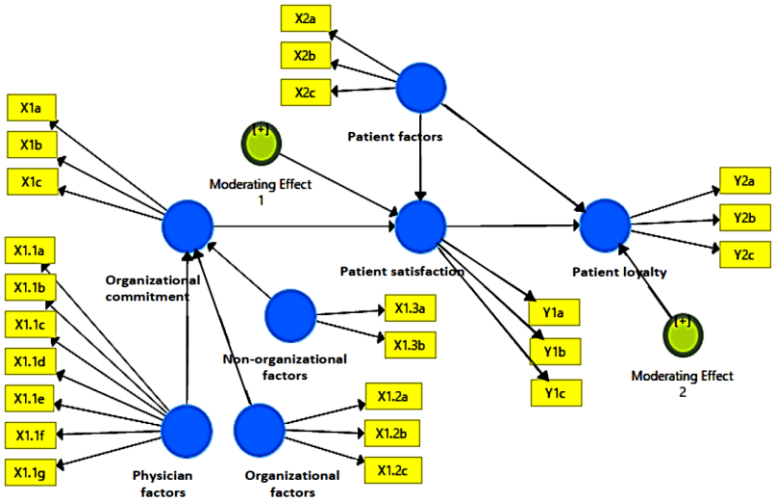


Figure 1. Theoretical path model of the study

## 3. RESULTS AND DISCUSSION

This study identify the causal relationship between organizational commitment, physician factors, organizational factors, non-organizational factors, patient satisfaction, and patient loyalty. The model proposed on this study assumes that physician organizational commitment is causally antecedent to patient satisfaction and patient loyalty. Physician organizational commitment, according to the model, leads to increased patient satisfaction and loyalty. According to empirical studies, three factors influence physician organizational commitment: physician factors, organizational factors, and non-organizational factors.

### 3.1. Evaluation of measurement model

The relationships between the observed variables were measured by using SmartPLS 3.0 and showing the results of outer loadings for the measurement model, path coefficients, and $R^2$ values. The initial estimates of the analysis PLS-SEM path model are shown in Figure 2. The results reveal the variables that affect organizational commitment, patient satisfaction, and patient loyalty. The indicator with the greatest external loading of the indicators is job opportunities and patient initiatives (0.934 and 0.925, respectively), followed by normative commitment, reward system, and health service standards (0.915, 0.907, and 0.905). The other indicators have loadings greater than 0.60, which indicates that all constructs are acceptable for outer loadings and further evaluation of the measurements model.

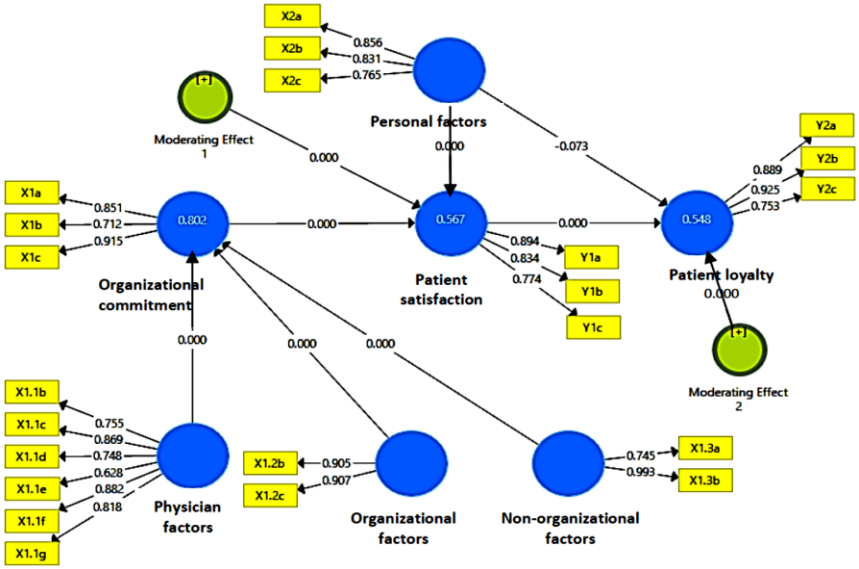


Figure 2. Analysis PLS-SEM path model first results

The researchers evaluate the reliability and validity of the reflective measurement models through the values of average variance extracted (AVE), composite reliability (CR), and Cronbach's alpha (CA) as shown in Table 3. Table 3 shows that at the initial values: AVE<0.5; composite reliability<0.7 and Cronbach's alpha<0.6. After the researchers discard the items with poor loadings, all AVE values>0.5; composite reliability value>0.7 and Cronbach's Alpha value>0.6. In general, the constructs exhibit the measures' reliability and convergent validity, as well as the relationship between constructs based on the study hypothesis.

Table 3. Results for reflective measurement models

| Variables | AVE | | Composite reliability | | Cronbach's Alpha | |
|---|---|---|---|---|---|---|
| | Initial | Improved | Initial | Improved | Initial | Improved |
| Patient factors | 0.67 | 0.67 | 0.859 | 0.859 | 0.761 | 0.761 |
| Patient satisfaction | 0.698 | 0.698 | 0.873 | 0.873 | 0.786 | 0.786 |
| Patient loyalty | 0.738 | 0.738 | 0.893 | 0.893 | 0.823 | 0.823 |
| Organizational commitment | 0.69 | 0.69 | 0.869 | 0.868 | 0.778 | 0.778 |
| Non-organizational factors | 0.77 | 0.77 | 0.868 | 0.868 | 0.794 | 0.794 |
| Organizational factors | 0.544 | 0.821 | 0.692 | 0.902 | 0.476 | 0.782 |
| Physician factors | 0.534 | 0.621 | 0.866 | 0.907 | 0.8 | 0.875 |
| Moderating effect 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Moderating effect 2 | 1 | 1 | 1 | 1 | 1 | 1 |

### 3.2. Evaluation of structural model

To evaluate the structural model, Figure 3 shows all the tcount values are the table value (1.96), so it can be summarized that Figure 3 is the final path model improved. This study shows that the physician organizational commitment is influenced by physician factors (6 indicators), organizational factors (2 indicators) and non-organizational factors (2 indicators). In addition to this, physician organizational commitment affects patient satisfaction and subsequently affects patient loyalty in first-level health facilities.

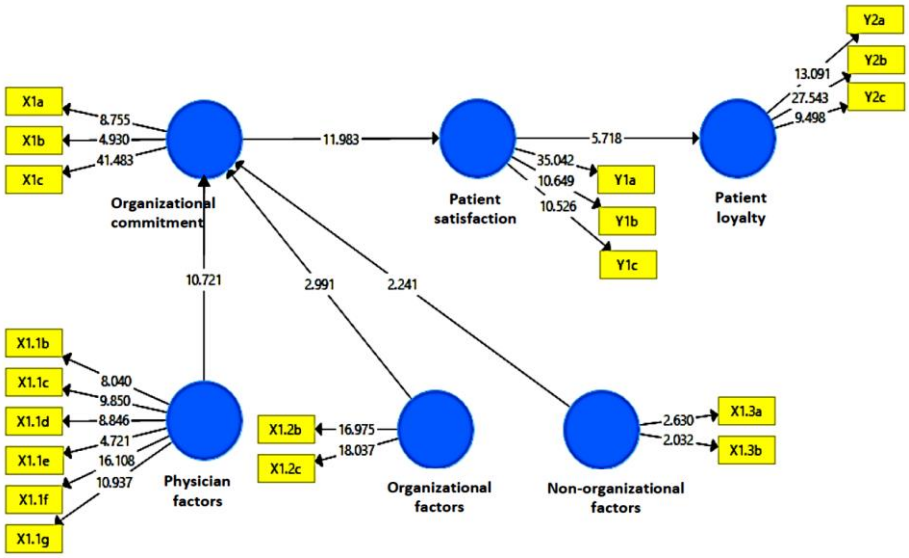


Figure 3. Analysis PLS-SEM path model improved

Table 4 identifies the results of the structural path model coefficients and the relevance of this significance. It shows that physician factors, organizational factors, and non-organizational factors influence physician organizational commitment. Additionally, non-organizational factors have a negative influence on physician organizational commitment (-0.233), in which a negative coefficient means that as non-organizational factors increase, physician organizational commitment is predicted to decrease. It can also be seen from Table 4 that physician organizational commitment has a positive effect on patient satisfaction (0.746). At the patient level, our results also suggest that patient satisfaction affects patient loyalty in first-level health facilities (0.735). This study shows that for every one-unit increase in patient satisfaction, the predicted value of patient loyalty increases by the value of 73.5%.

Table 4. Significance results of the structural path model coefficients

| Paths | Path coefficients | t | Sig. | Interpretation |
|---|---|---|---|---|
| Physician factors (X1.1) → Physician organizational commitment(X1) | 0.822 | 10.721 | 0.000 | Sig. |
| Organizational factors (X1.2) → Physician organizational commitment (X1) | 0.29 | 2.991 | 0.004 | Sig. |
| Non-organizational factors (X1.3) → Physician organizational commitment (X1) | -0.233 | 2.241 | 0.029 | Sig. |
| Physician organizational commitment (X1) → Patient satisfaction (Y1) | 0.746 | 11.983 | 0.000 | Sig. |
| Patient satisfaction (Y1) → Patient loyalty (Y2) | 0.735 | 5.718 | 0.000 | Sig. |

PLS-SEM is based on cause-predictive relationships since the expounded variance of dependent variables is maximized based on well-developed explanations [12], [13]. Because PLS path modelling is an approximation-based method created for circumstances with a theoretical foundation, researchers should be cautious when interpreting PLS path modelling results.

Table 5 shows that physician factors, organizational factors, and non-organizational factors have the strongest influence on physician organizational commitment (80.2%). Likewise, sometimes small values of R2 are particularly meaningful in social sciences [14]. In this study, physician organizational commitment has a moderate effect on patient satisfaction (55.6%), and patient satisfaction shows a moderately strong value for patient loyalty (54%) as well. Further, the Q-Square predictive relevance value is then determined

through the results of blindfolding procedure to see how well the observation value is generated from the structural model. The Q-Square value has a range of 0 to 1, where the closer the value to 1 means the structural model indicating better fit. The results of the blindfolding test show the value of Q-Square the largest is 0.677 which means that the model formed in the results of this study has a strong predictive relevance (fit model).

Table 5. Explanation of variance

| Constructs | $R^2$ |
|---|---|
| Physician organizational commitment | 0.802 |
| Patient satisfaction | 0.556 |
| Patient loyalty | 0.54 |

Indonesian national healthcare and social security, was begun in 2014 and is projected to cover nearly 100% of the Indonesian population with basic health care services in the following years. It has surely aided the expansion of hospital and clinic businesses by increasing the number of patients indirectly. Indonesian national healthcare and social security also has partnered with 27,217 first-level health facilities to provide holistic and comprehensive care services in stages based on their medical needs [15].

Patient health care needs are assessed using a holistic approach based on the patient's health. This comprehensive method includes parts of a holistic examination rather than just focusing on physical or biological issues, resulting in a more thorough management plan. A holistic approach to medical care would emphasize the necessity of understanding the patient's physical health, psychological health, and the need for harmony between individuals, as well as the social and natural surroundings [10].

In agreement with our H1, three factors influence organizational commitment: physician factors, organizational factors, and non-organizational factors. Physician factors include sex, age, years of professional experiences, duration of employment in first-level health facilities, employment status, training of holistic and comprehensive care, and training of national healthcare and social security program. Organizational factors comprise of mission, vision and values statements, health service standards, and reward system. Furthermore, non-organizational factors also include health policy of national healthcare and social security, and job opportunities.

The majority of physicians are middle-aged adults (36-45 years old) and female. According to previous research, the average age of 35 years old has a positive effect on organizational commitment. As a form of involvement in the organization, they have a stronger emotional attachment, are more critical in responding to an issue that exists in the organization, and try to help resolve existing problems [16]. Despite the fact that women are the majority in the study, gender has no statistically significant impact on organizational commitment [17].

Most physicians are in first-level health facilities for more than 10 years. Previous study show that the length of service has a substantial impact on occupational and continuation commitment. This emphasizes the importance of years of service in the long-term commitment in health facilities. In today's health professional's society, occupational commitment declined as years of service grew, while continuation commitment increased. The length of service was found to be positively associated to the organizational commitment (general), emotional commitment, and normative commitment [18]. As a government-owned health facility, the staffing status of physicians at public health centers is permanent. In contrast, not all of the doctors at the private clinics are full-time employees. The employment status at the private clinics is determined by the health facilities owner's policy. Employment status at public health centers has no bearing on the organizational commitment to providing holistic and comprehensive care. Because outsourced employees have a high desire to leave the institution due to a lack of a maximal and transparent promotion system to become permanent employees, management should also support outsourced employee that has good performance, by including job openings to become a full-time employee [19].

Physician factors, organizational factors, and non-organizational factors have the strongest influence on physician organizational commitment (80.2%). The majority of physicians have been involved in training of holistic and comprehensive care as well as national healthcare and social security. In accordance with regular operational processes to be carried out by first-level health facilities, it is undoubtedly highly supportive to supply patients with adequate health services. Physicians need to be able to develop through training programs to assist the execution of their tasks.

Vision and mission are essential elements to understand in order to attain an organization's goals. The first-level health facilities' vision, mission and aims impact the physician organizational commitment to offering holistic and comprehensive car for patients. All public health centers have vision, mission and goals,

however only one third private clinics that do not have a clear vision, mission and goals. In another study, employees' job satisfaction increases when they are aware of the organization's mission and vision. This could be an indicator of the organization's culture, which fosters positive values that are embedded in the vision and mission of the organization [20].

The standard for the management of first-level health facilities ensures effectiveness and efficiency in managing health service activities in accordance with their values, vision, mission, objectives, main tasks, and functions. The medical status of the patient is one source of guidance in offering holistic and comprehensive care. The physician's record of the main complaint, history, physical examination, and subsequent examinations that the physician must determine as a diagnosis is the patient's medical condition. The diagnosis will be enforced and managed. Health service standards that must be understood by physician in first-level health facilities are related to: i) physician competence, ii) holistic and comprehensive care, and iii) the referral system. The majority of physicians are familiar with the health-care standards that have been established in accordance with the applicable regulations.

Most physicians agreed that first-level health facilities provided both non-financial and financial rewards. The first criterion for employees is the amount of money they receive from their employer. Incentives can be used by the employer to improve their satisfaction and organizational commitment. Incentives are awards or rewards given to employees or members of an organization in order to motivate them to work efficiently and productively [18], [19].

Since starting in 2014, Indonesian national healthcare and social security is projected to cover nearly 100% of Indonesia's population with basic health services [14]. Accordingly, based on Indonesian Insurance Law No. 71 year 2013, public first-level health facilities are automatically designated to provide health services with the assistance of Indonesian national health insurance [21]. This study discovered that the collaboration between public first-level health facilities with Indonesian national healthcare and social security lasted more than 4 years. Based on data, there are 9,993 public first-level health facilities and 6,500 private first-level health facilities have joined the Indonesian national healthcare Partners program, which requires them to provide appropriate health care [22]. Similarly, private first-level health facilities have also been given permission to collaborate with this national health insurance, where it was discovered in this study that the collaborations have been going on for over four years. In accordance with government regulation, first-level health facilities and Indonesian national healthcare and social security must provide holistic and comprehensive health services in the form of promotive, preventive, curative, and rehabilitative health services [23].

Physicians are very knowledgeable about national healthcare and social security policies, and they must understand that health services in first-level health facilities are related to three aspects: i) 144 medical diagnoses, ii) national formulary, and iii) health service commitment-based capitation. The national formulary serves as a guideline for the minimum availability of medicines at each level of service. This does not mean that if a patient requires a medicine that is not on the national formulary, the patient is told to buy it himself; rather, the health facilities must provide the medicine when it is required for the management of the patient's clinical condition. Capitation is the number of monthly payments paid in advance by national healthcare and social security to first-level health facilities based on the number of registered patients, without taking into account the type of health services provided to patients or the number of patients who use health services at the first-level health facilities. The health service commitment-based capitation system includes three indicators: contact rate, percentage of active patient visits, and non-specialized referral ratio. The three indicators show an improvement from January to December, 2017. It is indicating that primary care providers' roles as gate keepers and care coordinators have improved [20]. Excellent healthcare services are expected to reduce referrals to advanced health services, allowing health costs at the first-level health facilities to be optimized. To carry out holistic and comprehensive care, then the patient's biopsychosocial condition must be determined.

The majority of physicians agreed that finding work outside of the first-level health facilities is difficult. Even if they have to leave, they stated that the awards will be the same, both non-material and material. On the other side, the organizational commitment reflects the dedication of the personnel to the organization. In other words, the strength of the identity and involvement of the individual with the organization [24].

Strategic human resource management is in charge of establishing employees' work-related attitudes in order to maximize output and maintain organizational balance. While organizational features can explain variances in employee commitment, their individual traits and working experiences mostly explain the differences. With regard to occupational disparities, personal support from leaders and coworkers has shown a stronger influence on organizational commitment in physicians [25]. Building a strong organizational commitment to implementing holistic and comprehensive care necessitates consideration of physician, organizational, and non-organizational factors. Physician factors are things that are related to individual circumstances, and this will form the initial commitment. Organizational factors will form and raise work

responsibility. Non-organizational factors will create other options for remaining in the organization or leaving the organization, affecting subsequent commitments.

According to H2, organizational commitment is measured using three indicators: affective commitment, continuance commitment, and normative commitment. Patient factors such as word of mouth, basic medical needs, and previous experiences receiving services at first-level health facilities can all influence their satisfaction. Physician affective commitment who worked in private clinics outperforms physician in public health centers. This is possible because, before deciding to join, they will have studied the system run by the private clinics. This affective commitment will encourage them to try to perform well, always contribute to and achieve the main goals.

The positive impact of employee commitment and loyalty demonstrated that if the employees of the organization believe that they work as an efficient person in the organization and that their relationship with the organization is very important. These people see the organization's problems as their problems, and leaving the organization would be extremely difficult for them [26]. Previous study shows that different aspects of service atmosphere may play different roles in improving customer satisfaction. There is an indirect relationship between service atmosphere and customer satisfaction. Therefore, managerial support and work facilitation have an indirect impact on customer satisfaction by increasing employee commitment [27], [28]. Patients perceive higher service quality when services are delivered by a dedicated employee. This emphasizes the importance of decision makers in the health care sector considering employee commitment as a competitive variable, which is frequently overlooked in their strategic plans. So, it can be argued that more committed employees lead to satisfied patients, resulting in a set of behavioral and financial outcomes [7].

In accordance with H3, this study demonstrates that patient satisfaction has a significant impact on patient loyalty. The success of healthcare providers and hospital management is dependent on patient loyalty. Accessibility, healthcare quality, services systems, patient- physician interaction processes, charges and price rise likely to enhance patient loyalty. Patient satisfaction might emerge owing to emotional or psychological circumstances in relation to previous experiences. Patient loyalty is a set of outcomes resulting from patients' commitment, trust, and satisfaction with medical services obtained during hospitalization. In this study, physician roles in increasing patient trust and satisfaction are critical. In addition to this, patient satisfaction occurs when physician is willing to conduct remote consultations prior to home visits. If patient loyalty is valued, medical service providers will create a system that allows patients to communicate with physician remotely, reducing patient costs. Physician's service to ameliorate disease, as well as considering socioeconomic variables, quality of care, and patient involvement during treatment all had a direct and beneficial impact on patient satisfaction [29], [30].

H4 specifies that the patient factors are taken into account when using certain types of first-level health facilities. The three reasons are: i) word of mouth, specifically the availability of information from other people about health services, ii) basic medical needs, and iii) prior experiences. This study shows that the primary reason for patients to use the first-level health facilities is to meet basic medical needs in order to solve health problems. This reasoning is supported by the influence of others, as evidenced by information provided by others and prior experiences.

The structural model demonstrates that patient factors have no direct effect on participant satisfaction. The patient factor was thought to be moderating the effect of organizational commitment on participant satisfaction and moderating the effect of participant satisfaction on participant loyalty in the initial research formulation. It is necessary to assess patient satisfaction with the health-care services offered. Some factors to consider include developing a mutualistic relationship between doctors and patients, which can increase patient satisfaction and loyalty. If the physician-patient relationship is strained, the organization must take a more active role in professional skill development through continuing education or training. Improving patient comfort while providing services, can lead to positive word-of-mouth referrals. Further, patients are satisfied if hospital administrators pay greater attention to their patients, reinforce hospital information, familiarize the hospital and the medical service procedures, and communicate adequately with regards to treatment and disease prognosis [30], [31]. Study also shows that the majority of patients appreciated the fact that physicians treated them as individuals rather than just another patient with a complaint. Patients appeared to be more satisfied with their consultation when physicians made an effort to engage them in conversation in order to understand them [32].

According to H5, the structural model of this study shows how variables might be related to the following: i) physician organizational commitment to implementing comprehensive holistic health services is directly influenced by personal, organizational, and non-organizational factors; ii) physician organizational commitment to implementing comprehensive holistic health services has an impact on patient satisfaction; and iii) patient satisfaction affects patient loyalty. The impact of non-organizational factors on physician organizational commitment demonstrates a negative value which results in the lower the physician

organizational commitment by the greater influence of non-organizational factors. On the other hand, the lesser the effect of non-organizational factors will increase the physician organizational commitment.

Previous research has shown that personal factors are related and have a significant impact on employee organizational commitment. These factors play a significant role in determining individuals or groups' organizational commitment [31]. In addition to this, strong coworker and supervisor support both contribute to affective commitment, emphasizing the importance of these relationships to the employee. A supervisor who provides support, shares concerns, and provides useful job-related information is likely to have a positive impact on employees' organizational commitment. Coworkers provide mutual support for one another in terms of information and assistance, which increases their sense of connection and commitment to the institution [33], [34].

Organizational commitment is classified into three types: affective commitment, continuance commitment, and normative commitment. The emotional attachment an employee has to the organization and its goals is referred to as affective commitment. Because of the costs associated with leaving the organization, continuance commitment demonstrates cognitive attachment between an employee and his or her organization. Finally, normative commitment refers to the common sense of obligation to stay with an organization. Organizational commitment is a critical factor in achieving higher quality health care services, and it is also related to provider job satisfaction. Furthermore, care is at the center of these practices and plays a significant influence in determining patient satisfaction with the health services' experiences [35], [36].

H6 specifies that patient factors do not directly affect patient satisfaction and loyalty, yet patient satisfaction will rise in tandem with the quality of care provided by the health facilities. When a patient is satisfied, he will spread the word or say positive things to the people around him, which then will improve the hospital's image and their tendencies to reuse the health services. Patient satisfaction with the health care provided has to be assessed. Some of the things needed to be examined include the establishment of reciprocal relationships between physicians and patients. Enhancing patient comfort with services can lead to good word of mouth. A service recipient evaluates the quality of the service based on the actual service and interactions with the service provider. Interaction with a service provider is a critical factor in overall patient satisfaction [3]. The high level of patient loyalty to first-level health facilities will reduce the likelihood of patients moving health facilities, and reduce the health service commitment-based capitation.

Physician organizational commitment to implementing comprehensive holistic health services needs to be strengthened through the following efforts: Providing health and comprehensive training, national healthcare and social security program is being disseminated, and developing first-level health facilities' vision, mission, and objectives in accordance with the concept of holistic and comprehensive services and putting them into actions. Patient satisfaction must be improved by enforcing holistic diagnosis (biopsychosocial) and providing comprehensive management through promotional, preventive, curative, and rehabilitative efforts.

This study did not assess the variables that may influence organizational commitment, such as job expectations, job choices, initial work experience, and scope of work. It is suggested that future research look more closely at the various personal and organizational factors that influence physicians' organizational commitment. It is also frequently discovered that health service users have no other options when using the same health facility; this can be a bias factor that should be considered in future research.

## 4. CONCLUSION

In conclusion, the findings are extremely valuable for physicians and first-level health facilities, as physician organizational commitment has a significant impact on patient satisfaction and loyalty. These health facilities can create a vision, mission, and goals that align with the goals of Indonesian health services to promote physician organizational commitment. The implementation of holistic and comprehensive treatment standards by physicians is also advocated.

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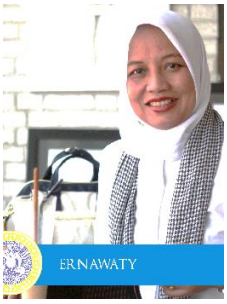


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