

COMPARATIVE EVALUATION OF PATIENT SATISFACTION AND WILLINGNESS TO UTILIZE ORAL REHABILITATION SERVICES ACROSS DIFFERENT DENTAL HEALTHCARE SYSTEMS IN CHENNAI

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ABSTRACT

Background: Patient satisfaction is an important indicator of the quality of healthcare services and plays a significant role in the utilization of oral rehabilitation services. Differences in accessibility, affordability, waiting time, and quality of care among government, private, institutional, and corporate dental healthcare systems may influence patient satisfaction and willingness to continue treatment. This study aimed to compare patient satisfaction and willingness to utilize oral rehabilitation services across different dental healthcare systems in Chennai.

Materials and Methods: A questionnaire-based analytical cross-sectional comparative study was conducted among **400 adult patients** receiving oral rehabilitation services in government dental hospitals, private dental clinics, dental teaching institutions, and corporate dental centers in Chennai. Participants were selected using a stratified sampling technique. Data were collected using a structured, pre-tested questionnaire assessing demographic characteristics, patient satisfaction, and willingness to continue treatment. Descriptive statistics were used to summarize the data. One-way ANOVA compared satisfaction scores among healthcare systems, Chi-square tests evaluated associations between categorical variables, and multivariate linear regression identified predictors of patient satisfaction. Statistical analysis was performed using IBM SPSS Statistics, with a significance level of $p < 0.05$.

Results: Private dental healthcare facilities were the most frequently utilized (37.0%), followed by institutional (27.0%), government (24.0%), and corporate centers (12.0%). Patient satisfaction differed significantly among healthcare systems ($F = 5.52$, $p = 0.001$), with corporate healthcare centers reporting the highest mean satisfaction score (44.08 ± 4.64), followed by private (42.89 ± 6.17), institutional (41.56 ± 4.09), and government facilities (40.71 ± 6.04). Educational status, occupation, and monthly income were significantly associated with patient satisfaction ($p < 0.001$), whereas gender showed no significant association ($p = 0.074$). Overall, **93.0%** of participants were willing to continue treatment; however, willingness to continue treatment did not differ significantly across healthcare systems ($\chi^2 = 2.476$, $p = 0.480$). Multivariate regression analysis showed that age, gender, and healthcare system were not significant predictors of satisfaction.

Conclusion: Patient satisfaction with oral rehabilitation services varied significantly across dental healthcare systems, with corporate and private facilities demonstrating higher satisfaction levels than institutional and government centers. Socioeconomic factors, particularly education, occupation, and income, significantly influenced patient satisfaction, whereas willingness to continue treatment remained consistently high regardless of the healthcare setting. These findings highlight the need to improve patient-centered care, accessibility, and

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service quality across all dental healthcare systems to enhance patient satisfaction and promote the utilization of oral rehabilitation services.

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INTRODUCTION:

India's healthcare system consists of a public and a private sector providing a wide range of healthcare services to the country's citizens (1). The public healthcare system comprises primary, secondary, and tertiary institutions offering subsidised and affordable services to the citizens. On the other hand, the private healthcare system is made up of private clinics, multi-specialty hospitals, corporate hospitals, and dental schools offering specialised services on fees-paying basis. A variety of healthcare systems ensures that citizens receive better healthcare services; however, there are disparities in terms of affordability, accessibility, quality, and patient experience (2).

Dental healthcare services are available in India through government hospitals, private clinics, dental institutions, and corporate hospitals (3). South India has a higher concentration of dental colleges and specialisations compared to other regions in the country (4). Nonetheless, the distribution of dental healthcare services is not equal throughout India due to variations in terms of socio-economic status, dental awareness, financial status, and the perceived quality of care. There has been an improvement in dental materials and technologies to offer a variety of oral rehabilitation services. However, there is a disparity in the use of oral rehabilitation services in India.

Oral rehabilitation services such as prosthodontics are available at government hospitals at subsidised fees. Nonetheless, patients might experience long waiting lists, insufficient human resources, multiple appointment scheduling, laboratory work, and resource unavailability (5). Prosthodontics involves the use of removable partials, complete dentures, crowns, bridges, and implants, which might require multiple visits to the clinic and laboratory before the fabrication process is completed, thus lowering patient satisfaction (6).

Private dental colleges are a better option compared to private dental clinics because patients receive professional services involving multi-specialty consultations at an affordable cost. Dental institutions offer services such as diagnosis and treatment in a professional and clinical setting under the supervision of experienced professors and

doctors (7). Although dental rehabilitation requires multiple visits to the institution, it is a cost-effective option for patients seeking a balance between cost and quality of service.

The primary reason why patients utilise oral rehabilitation services in India is due to the out-of-pocket nature of most health insurance, limiting the patient's ability to choose the type of care they need. Prosthodontic services can be costly depending on the materials used in the treatment, thus deterring moderately and low-income earners from seeking dental rehabilitation services (8). Therefore, most patients consider the cost of treatment, accessibility of the dental clinic, waiting lists, and communication when choosing a suitable dental institution (9). Patients are more likely to visit private clinics due to their accessibility, short-term consultations, and minimal waiting lists, whereas government-run institutions offer affordable services despite the long queues and lack of resources.

Furthermore, patient perspectives on the healthcare system are determined by their socio-economic status (SES) whereby individuals with higher income and education are more likely to visit private institutions offering advanced technologies, minimal waiting lists, and shorter treatment durations. Meanwhile, patients with low SES are more likely to utilise government hospitals because of the high costs associated with private hospitals (10). For example, the Pradhan Mantri Jan Arogya Yojana (PM-JAY), India's flagship public health insurance scheme, covers nearly all hospitalisation expenses for low-income families (11). Nonetheless, most dental treatments, including prosthodontics, are not covered by the insurance plan, thus limiting the poor from accessing affordable dental rehabilitation services in India (12).

There is limited information comparing the perspectives and willingness to pay for oral rehabilitation services among patients attending government, private, institutional, and corporate hospitals (13). Understanding the patient's views on the healthcare system in relation to oral rehabilitation services will help in developing successful strategies for improving the use of oral rehabilitation services in India.

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The objective of the study is to determine the perspectives and willingness to pay for oral rehabilitation services among patients attending government, private, institutional, and corporate hospitals in Chennai (14). The study aims to establish the factors influencing patient satisfaction and the use of oral rehabilitation services in Chennai. The study will focus on patients' willingness to utilise oral rehabilitation services in relation to the cost of treatment, accessibility of the clinics, waiting lists, treatment duration, and communication (15). Additionally, the research will examine the role of socio-demographic factors on the accessibility to, utilisation of, and patient satisfaction with oral rehabilitation services.

MATERIALS AND METHODS:

A questionnaire-based analytical cross-sectional comparative study was conducted to compare patient satisfaction and willingness to utilize oral rehabilitation services across different dental healthcare systems in Chennai, Tamil Nadu, India. The study was carried out in government dental hospitals, private dental clinics, dental teaching institutions, and corporate dental service centers over a period of four months from April 2026 to July 2026. Participants were recruited during routine outpatient visits from dental outpatient departments.

The study population consisted of adult patients requiring or having undergone oral rehabilitation procedures. Patients aged 18 years and above who had received or were receiving oral rehabilitation treatment, including complete or partial dentures, crowns, bridges, and dental implants, and who were willing to provide written informed consent were included in the study. Medically compromised patients, individuals unwilling to participate, and those unable to understand or complete the questionnaire were excluded. A stratified sampling technique was adopted to ensure proportional representation of participants from government, private, institutional, and corporate dental healthcare settings.

The primary outcome variables were patient satisfaction and willingness to utilize oral rehabilitation services. Independent variables included the type of healthcare system, age, gender, educational level, occupation, socioeconomic status, type of oral rehabilitation received, and duration of treatment. Potential confounding variables such as treatment cost, waiting time, accessibility of services, previous dental experience, and dentist-patient communication were also considered during the analysis.

Data were collected using a structured, pre-tested, interviewer-administered questionnaire comprising four sections. The first section recorded demographic information, including age, gender, educational qualification, occupation, and socioeconomic status. The second section collected treatment-related information such as the type of oral rehabilitation, duration of treatment, and the healthcare facility where treatment was received. The third section assessed patient satisfaction using a five-point Likert scale ranging from Very Satisfied (1) to Very Dissatisfied (5). This section evaluated satisfaction with treatment quality, treatment cost, waiting time, dentist-patient communication, infrastructure, cleanliness, and the overall treatment experience. The fourth section assessed participants' willingness to utilize oral rehabilitation services by evaluating their willingness to continue treatment, recommend the healthcare facility to others, seek future treatment from the same institution, perceived affordability, and awareness of available treatment options.

To minimize potential sources of bias, the questionnaire was standardized and pilot-tested before data collection. Investigators received training to ensure uniform administration of the questionnaire, and an interviewer-assisted approach was adopted to reduce misinterpretation of questions and improve response accuracy. Participant confidentiality and anonymity were maintained throughout the study to minimize response and social desirability bias.

The sample size was calculated using OpenEpi Version 3 based on the formula for estimating proportions: $n = [DEFF \times N \times p(1-p)] / [(d^2 / Z^2_{1-\alpha/2} \times (N-1)) + p(1-p)]$. Assuming a large population ($N = 1,000,000$), an expected prevalence (p) of 50%, a 95% confidence level ($Z = 1.96$), a precision (d) of 5%, and a design effect of 1, the minimum required sample size was calculated to be 384 participants. To enhance the precision of the estimates and improve the representativeness of the study population across the four healthcare systems, a total of 400 participants were included in the study.

Patient satisfaction scores were quantified by assigning numerical values to the five-point Likert scale responses (Very satisfied = 5, Satisfied = 4, Neutral = 3, Dissatisfied = 2, and Very dissatisfied = 1). Overall satisfaction scores were obtained by summing the responses to all satisfaction-related items. Continuous variables were expressed as mean $\pm$ standard deviation, whereas categorical variables were presented as frequencies and percentages.

Data were entered into Microsoft Excel and analyzed using IBM SPSS Statistics version 26.0. Descriptive statistics were used to summarize the study variables. Associations between categorical

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variables were evaluated using the Chi-square test, while one-way analysis of variance (ANOVA) was used to compare mean satisfaction scores among the four healthcare systems. Independent-samples *t*-test was applied where appropriate. Subgroup analyses were performed to compare patient satisfaction and willingness to utilize oral rehabilitation services across government, private, institutional, and corporate healthcare settings and according to demographic variables, including age, gender, and socioeconomic status. A two-tailed *p*-value of less than 0.05 was considered statistically significant.

RESULTS:

Table 1. Distribution of Participants According to the Dental Healthcare System

Healthcare System	Percentage
Private	37.00%
Institutional (Teaching)	27.00%
Government	24.00%
Corporate	12.00%
Total	100%

Table 1 presents a table that indicates the frequency of participants who were served in different health care systems regarding dental care. Most of the participants used private health care centers (37.0%), teaching hospitals (27.0%), government hospitals (24.0%), and corporate hospitals (12.0%).

Table 2. Comparison of Satisfaction Scores Across Different Healthcare Systems Among Study Participants.

Healthcare System	Mean $\pm$ SD				
Corporate	44.08 $\pm$ 4.64				
Private	42.89 $\pm$ 6.17				
Institutional	41.56 $\pm$ 4.09				
Government	40.71 $\pm$ 6.04				
Source of Variation	SS	df	M S	F	p-value
Between Groups	496.5	3	165.5	5.52	0.001
Within Groups (Error)	11,863.70	396	29.96		
Total	12,360.20	400			

One way ANOVA of variance; P – value < 0.05 shows statistical significance

Table 2 shows the comparison of the satisfaction scores in relation to various healthcare systems among the study participants. Participants who were undergoing treatment in corporate healthcare facilities had the highest mean satisfaction score (44.08 $\pm$ 4.64), followed by the private (42.89 $\pm$ 6.17), institutional (teaching) (41.56 $\pm$ 4.09), and government facilities (40.71 $\pm$ 6.04).

One-way analysis of variance (ANOVA) showed a significant difference in satisfaction scores among the four health care systems ($F = 5.52$, $p = 0.001$). Corporate and private healthcare systems showed higher scores regarding patients' satisfaction as a result of good infrastructures, equipment, waiting time, and patient centeredness. On the contrary, low scores of satisfactions in government facilities could be because of poor accessibility, long waiting time and resource availability.

Table 3: Association of Sociodemographic Characteristics with Satisfaction Score Among Dental Patients

Variable	Category	n (%)	Mean Satisfaction Score $\pm$ SD	Test Statistic	p-value
Gender	Male	188 (47.0)	3.73 $\pm$ 0.52	$t = -1.809$	0.074
	Female	208 (52.0)	3.91 $\pm$ 0.46		
	Other	4 (1.0)			
Education	Illiterate	52 (13.0)	3.37 $\pm$ 0.76	$F = 6.854$	<0.01*
	Primary	28 (7.0)	3.52 $\pm$ 0.37		
	Secondary	68 (17.0)	3.71 $\pm$ 0.40		
	Graduate	144 (36.0)	3.94 $\pm$ 0.37		
	Postgraduate	108 (27.0)	4.06 $\pm$ 0.40		
Occupation	Student	48 (12.0)	4.29 $\pm$ 0.42	$F = 11.563$	<0.0

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	Empl oyed	164 (41 .0)	3.94 ± 0.35		
	Self- empl oyed	92 (23 .0)	3.88 ± 0.37		
	Retir ed	16 (4. 0)	3.59 ± 0.35		
	Une mplo yed	80 (20 .0)	3.34 ± 0.59		
Mont hly Inco me	< ₹10,0 00	80 (20 .0)	3.65 ± 0.80	12.5 426	<0 .0 01 *
	₹10,0 00– 30,00 0	172 (43 .0)	3.77 ± 0.36		
	₹30,0 00– 50,00 0	108 (27 .0)	3.93 ± 0.32		
	> ₹50,0 00	40 (10 .0)	4.17 ± 0.51		

Chi square test; P – value < 0.05 shows statistical significance

Table 3 shows the relationship between the selected sociodemographic variables and the satisfaction score in dental patients. The mean satisfaction score was found to be higher in female subjects (3.91 ± 0.46) than male subjects (3.73 ± 0.52); however, there is no statistical significance in gender ($t = -1.809$, $p = 0.074$). Thus, gender does not have an influence on patient satisfaction.

Educational status has a statistically significant association with satisfaction score ($F = 6.854$, $p < 0.001$). Satisfaction score increases with the rise in education level, from illiterate (3.37 ± 0.76) to postgraduates (4.06 ± 0.40). This implies that educated people are satisfied with the dental health care services provided.

Occupation has a statistically significant association with the satisfaction score ($F = 11.563$, $p < 0.001$). Highest satisfaction scores were recorded in students (4.29 ± 0.42) followed by employed subjects (3.94 ± 0.35) and self-employed (3.88 ± 0.37). Lowest satisfaction score was reported by unemployed subjects (3.34 ± 0.59).

Likewise, there was a significant correlation between monthly income and satisfaction score ($F =$

12.543, $p < 0.001$). The subjects whose monthly income is more than ₹50,000 had the highest satisfaction scores (4.17 ± 0.51), while the subjects whose monthly income is less than ₹10,000 had the lowest scores (3.65 ± 0.80). It is evident that there was an increasing trend in satisfaction as the monthly income increased.

In conclusion, educational status, occupation, and monthly income are significant factors in determining patient satisfaction with dental healthcare, but gender is not.

Table 4: Association Between Healthcare System and Willingness to Continue Treatment Among Study Participants

Healthc are System	Continue Treatment Yes n (%)	Continue Treatment No n (%)	Total n (%)
Govern ment	88 (91.7)	8 (8.3)	96 (100. 0)
Private	136 (91.9)	12 (8.1)	148 (100. 0)
Corpora te	44 (91.7)	4 (8.3)	48 (100. 0)
Instituti onal	104 (96.3)	4 (3.7)	108 (100. 0)
Total	372 (93.0)	28 (7.0)	400 (100. 0)
χ^2 (df = 3)	2.476	p-value	0.48

Chi square test; P – value < 0.05 shows statistical significance

Table 4 above shows the relationship between healthcare system used and patients' willingness to continue treatment in the same facilities. In general, 372 (93.0%) patients were willing to continue with their treatment, while only 28 (7.0%) were unwilling.

Out of the various types of healthcare system, the highest percentage of patients willing to continue their treatment was recorded in institutional healthcare facilities (96.3%), private facilities (91.9%) and government or corporate facilities (91.7%). While there was a little bit of difference in the continuation rate in institutional facilities, the differences in healthcare system were insignificant.

The chi-square test did not show any significant association between the type of healthcare system and willingness to continue treatment ($\chi^2 = 2.476$, $df = 3$, $p = 0.480$). Because the p-value was higher than

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0.05, the null hypothesis was accepted, meaning that there is no relation between willingness to continue treatment and the healthcare system used.

affects the choice of the health care system but not education status.

Table 5: Regression Coefficients for Predictors Associated with Patient Satisfaction

Predictor	Coefficient (β)	p-value
Age	-0.034	0.369
Male	-1.594	0.12
Other Gender	7.269	0.158
Government Facility	-3.083	0.083
Institutional Facility	-2.479	0.154
Private Facility	-1.826	0.291

Multivariate Regression analysis; P – value < 0.05 shows statistical significance

Table 5 shows Multivariate linear regression analysis found that age ($\beta = -0.034$, $p = 0.369$), gender (male: $\beta = -1.594$, $p = 0.120$; other gender: $\beta = 7.269$, $p = 0.158$), and type of health facility (government: $\beta = -3.083$, $p = 0.083$; institutional: $\beta = -2.479$, $p = 0.154$; private: $\beta = -1.826$, $p = 0.291$) were not significant predictors of satisfaction score. While people receiving treatment at government, institutional, and private facilities had lower satisfaction scores than those who received treatment in corporate facilities, the difference was not significant.

Table 6: Association of Educational Status and Monthly Income with Selection of Healthcare System among Study Participants

Variable	Chi-square (χ^2)	df	p-value
Education vs Selection of Healthcare System	16.54	12	0.168
Monthly Income vs Selection of Healthcare System	31.5	9	<0.001*

Chi-square test; p-value < 0.05 shows statistically significant

A Chi-Square test for Independence was used to determine the relationship between educational status, income per month, and the choice of the health care system. There was no statistically significant relationship between educational status and choice of the health care system ($\chi^2 = 16.54$, $df = 12$, $p = 0.168$). Nevertheless, there was a statistically significant relationship between income per month and choice of the health care system ($\chi^2 = 31.50$, $df = 9$, $p < 0.001$). Thus, income per month

DISCUSSION:

The current study aimed to compare the patient's satisfaction and willingness to seek oral rehabilitation services in different dental healthcare systems in Chennai. The results indicated that there was no uniform pattern of patient's satisfaction and willingness to seek oral rehabilitation services among government, private, institutional, and corporate dental healthcare systems. Moreover, the results revealed that although the level of satisfaction varied among the included dental healthcare systems, the willingness to continue receiving treatment remained consistent.

The private dental healthcare system was the most preferred one, followed by institutional, government, and corporate dental healthcare systems. Such preferences could be explained by the availability and accessibility of the private healthcare system, which offers short wait times and advanced technology. Institutional hospitals seemed to attract more patients due to the opportunity to receive specialized affordable treatment. Furthermore, the corporate healthcare system seemed to provide the best patient experience, followed by private, institutional, and government dental healthcare systems.

There was a significant relationship between sociodemographic characteristics and the patient's satisfaction with treatment. More specifically, compared to females, males were more likely to be satisfied with treatment. The study also revealed that the level of satisfaction with treatment depended on the patient's educational status and occupation. Patients with higher education and those employed reported higher satisfaction levels, which might be explained by their increased awareness and ability to pay for treatment. In addition, the results showed that among the compared groups, the students were the most satisfied ones, whereas the unemployed participants were the least satisfied ones.

Even though there was a difference in patient satisfaction with treatment in the compared healthcare systems, the results revealed that more than 90% of the participants were willing to continue seeking care in the selected healthcare systems. Additionally, the study did not reveal any significant relationship between the willingness to continue seeking care and the healthcare system type. Such findings could indicate that the oral healthcare setting affects the patient's decision to continue receiving treatment.

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When controlling for covariates, the multivariate analysis revealed that age, gender, and healthcare systems were not significant predictors of patient satisfaction with treatment. The analysis also showed that the monthly income significantly predicted the healthcare system choice, whereas the educational status did not contribute to the prediction of the healthcare system choice. Finally, the findings revealed that the participants' satisfaction with treatment did not differ between the compared healthcare systems.

The results of the current study indicated that the patient's satisfaction with treatment and willingness to continue seeking oral rehabilitation services in different healthcare systems depended on the healthcare system type and the patient's socioeconomic characteristics. Moreover, the current study revealed that the patient's satisfaction with treatment was related to their perception of the healthcare system infrastructure and services, which could be improved by providing better treatment environments, including short wait times, and personalized patient-centered approaches.

However, the results of this current study agree with numerous earlier studies. In line with Narayanan and Greco who noted high levels of patient satisfaction via the Dental Practice Questionnaire (DPQ) in Australian dental practices, this current study has also revealed high levels of patient satisfaction especially in corporate and private healthcare settings due to the importance of communication and accessibility (16). In a similar vein, Moldovan et al. also noted a statistically significant level of patient satisfaction among patients who visited private dental clinics compared to those who visited public clinics in Romania, an observation that corresponds with the result of this current study which shows that corporate and private healthcare facilities have significantly higher satisfaction scores than government hospitals (17). This is also supported by the result of a study conducted by Khan et al. in Saudi Arabia where patients visiting private dental clinics had 27% higher satisfaction levels than those visiting public clinics, attributed to good infrastructure, experienced dental practitioners, and effective appointment procedures which are similar to the findings of this current study (18).

However, there are some inconsistencies between some of the findings of the present study and those of earlier studies. For instance, while the current study showed that satisfaction increases with an increase in educational status, Hussein et al., Aldossary et al., Amorim et al., Fernandez et al., and Macarevich et al. found that patients with high levels of education have lower levels of satisfaction since their expectations about healthcare services were relatively high (19). On the other hand, even though

women reported slightly higher levels of satisfaction in the current study, gender had no significant relationship with patient satisfaction. Contrarily, Armfield et al. and Hussein et al. found that females have significantly higher levels of satisfaction than men (20), but Al-Harbi et al. found higher levels of satisfaction in male patients (21). In terms of age, age had no significant effect on patient satisfaction according to the current study despite being used as a covariate in the multivariate model (22). Nonetheless, Narayanan and Greco found that young people have low levels of satisfaction (23), while Fernandez et al. found that older adults have lower levels of satisfaction at health care delivery system (24). The current study involved four health care organizations and found that corporative dental health care organizations had the highest scores of satisfactions, which indicated that better health care infrastructure, new technologies and comprehensive patient services might provide further advantages compared to traditional private practices. Lastly, in contrast with the conclusions made by Zhang et al. that communication and treatment outcomes were better predictors of patient satisfaction compared to the structure of dental health care (25), the current study has found that health care structure, waiting time and efficiency have significant influence on patient satisfaction.

The main strength of this study lies in its extensive review of patient satisfaction and their willingness to make use of oral rehabilitation services within the context of four different dental health care systems, which are the government, private, institution, and corporate health care systems. As opposed to the other studies that only examine the limited health care sectors, this study makes use of the more extensive health care systems to make the study results more representative. Besides measuring the satisfaction level of the patients, the study also measured the willingness of the patients to continue making use of the health care service. Moreover, demographic and socioeconomic factors like age, gender, education, occupation, and income level were considered to find out the effect of these variables on patient satisfaction and health care system choice.

Nevertheless, this research is subject to certain limitations. The cross-sectional nature of the study limits the capability of the researcher to develop causal relationships between the variables patient characteristics, choice of healthcare system and satisfaction outcomes. The research having been carried out in selected dental healthcare facilities in Chennai cannot be generalizable to the rural population or other geographical regions with different healthcare systems. The measure of patient satisfaction has been done through self-reporting at one point in time, which can have an impact on

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recall and response bias, and does not necessarily represent the long-term satisfaction after treatment is completed. Clinical outcome of treatment, quality of prosthesis, level of rehabilitation, treatment period, the experience of dentists and long-term maintenance and follow-up have not been considered.

Other limitations of this research are that there was no assessment of psychological and sociocultural factors, such as dental anxiety, patient expectations, past experiences with dentistry, and cultural preferences, which might impact patient satisfaction. In addition, disparities in oral health status, systemic health problems, numbers of missing teeth, insurance status, reimbursement issues, and socioeconomic disadvantage could not be fully controlled. Also, the uneven distribution of subjects across healthcare providers, as well as possible selection bias as a result of non-participation, may have impacted the results. Even though a multivariate analysis was carried out, some remaining confounders can still not be ruled out.

Further research should consider longitudinal and multicentred studies to study the long-term patient satisfaction and outcome under different dental health care systems. Further research should include clinical outcomes, cost of treatment, waiting time, accessibility, insurance, dental anxiety, patient's expectation, and dentist-patient communication. Intervention and qualitative studies may focus on patients' experience and evaluate techniques like improvement in appointment system, less waiting time, good communication, and patient-focused care for better use of oral rehabilitation facilities.

CONCLUSION:

The level of satisfaction among patients seeking oral rehabilitation services was highly significant between different dental healthcare systems, with corporate and private dental clinics being more satisfactory than institutional and governmental dental clinics. Sociodemographic variables like education, occupation, and income level had significant associations with patient satisfaction, but the willingness to receive dental care was high for all patients seeking dental healthcare systems. These results underscore the necessity of developing patient-oriented care practices, increasing accessibility, minimizing service barriers, and improving the quality of care within all dental healthcare systems.

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