The quality factors that differentiate health services in public and private sectors from the customer satisfaction standpoint

A study of Romanian healthcare services

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Abstract

The purpose of this thesis is to identify the quality factors that differentiate the public healthcare system from the public healthcare system in Romania, from the customer satisfaction point of view. Specifically, this document studies the main factors that differentiate the public from the private practice in the perception of the patient, his expectations and degree of satisfaction towards each service.

The research was conducted using quantitative and qualitative designs. The first method consisted in questionnaire developed for urban and rural patients in Cluj County, Romania. The second method allowed the researcher to gain staff and management insight into the matter by collecting data through a focus group on the premises of Medisprof Clinic in Cluj-Napoca, Romania.

The findings show that there is an important gap, between healthcare service quality in a public facility and service quality in a private facility. Patients have a better image of private healthcare services and in accord with this, greater expectations. Furthermore, while there is a perception of greater cost of private services, they are viewed as more professional and having better equipment. Overall, the elements that drive patient satisfaction are reliability and assurance, and they are more satisfied with private healthcare services.

This research is valuable because of the current debate over the state of the Romanian healthcare system. Moreover, this paper points out important issues with the quality of services from a neglected perspective, that of the patient. The practical implications of this research are key to private healthcare businesses who wish to thrive and expand as well as to public facilities that are interested in improving their services.
1 INTRODUCTION

1.1 Researcher background

The researcher, of Romanian origin, has studied marketing in France for four years before enrolling in a master’s degree course at the DBS. During the first four years of study, the researcher has spent more than six months working in a healthcare specialized company, Medisprof Ltd. The interest for this domain, and the desire of working in healthcare services, have led to this proposed research. The researcher is therefore suited to conduct this research as the basic knowledge of healthcare organizations is acquired.

1.2 Research context

The context in which the research will be conducted is one of financial instability, political turbulence and generalized low status of health in Romanian population. The main problems of the public healthcare system concur with those of other European countries and they consist firstly of access problems, specifically the difference between urban and rural areas and doctor availabilities. Furthermore, the Romanian public health system is based on involuntary health insurance taxation of the population and the current healthcare expenditure (4.4% of country GDP) is the smallest of all the E.U. states (Eurostat). The World Health Organization enriches this data with information concerning the average expenditure on health per capita which is situated at less than $500. It does not cover actual needs of the population in terms of medical supplies and equipment. Moreover, the public system is subject to corruption which cripples healthcare to the point of which it has become tradition in Romania. In this context the private healthcare providers have flourished, giving patients better access, better healthcare services and value-for-money. The private sector has quickly developed in the last years and in many sectors has surpassed the public healthcare sector (Figure 1). Private hospitals are almost eight times what they were in 2005, when there were 11 private hospitals from a total of 433, passing to 97 out of 464 in 2011.
The last census situated the Romanian population at about 21 million. As of 2012, partial census data is available and it shows a population of 19 million people with approximately 55% living in urban areas.

Socio-economic factors have great influence upon the state of health, particularly poverty, social inequities and unemployment. “The all-cause mortality rate showed a constant increase from 10.7 deaths/1000 inhabitants in 1989 to 11.9 deaths/1000 inhabitants in 2004 (a slight reduction from 12.4 deaths/1000 inhabitants in 2002)” (source: Neonat). The main causes of death are cardiovascular disease (62%), malignant tumors (17%), digestive diseases (6%), accidents, injuries and poisoning (5%), and respiratory diseases (5%). Mortality amongst women is increasing, with more and more breast and cervical cancer.

As a new government has been established since the last elections at the end of 2012, a new minister of health has presented a number of ideas included in a new law project for healthcare. This project includes a new health insurance system, which would set a basic insurance plan sustained by the government and additional insurance would be paid by the patient. In this way, the health expenditure will only partially be sustained by
the public budget. Another important clause of this law project refers to the funding (payment of services and medical supplies) of the private hospitals and clinics which work in contract with the National Health Insurance House (the Romanian organism which manages public health funds). This clause states that funding will only be given to private hospitals if the demand exceeds the offer of the public sector. This aims to limit the development of private hospitals and clinics. This law is set to be voted on in May 2013.

1.3 Reasons for research

In order to justify the relevance of the research, the author must ask: “who will benefit from this?”, “is this research really necessary and important in this sector?”, “will this research bring a new academic perspective?”

A considerable amount of academic research has been done in developing a framework for service quality. Frameworks like SERVQUAL have been acknowledged as the basics for analyzing quality in services and have been modified to suit different sectors, healthcare included. This research offers a chance to test those conceptual models.

Overall, there are four reasons for this research:

- The patients: it would give the patients an idea of what to look for when selecting a private or public service, it would help them make their choices.
- Private healthcare sector has reached a critical mass in Romania and it is quickly developing. The patient expectations and perceptions are essential in assessing service quality and the choice of clinical institutions. This is why this research would help private practices better understanding patient choices and what drives the growth.
- The current debate: the Romanian health minister is proposing to cut the public funding that pays medical supplies and services to the private sector (currently 10% of healthcare annual budget). This has started a public debate, where some private practices like oncology hospitals are struggling to maintain current funding or risk becoming insolvent. The debate has gone to
the roots of healthcare basic ideology in Romania (free healthcare services) and this research could provide an argument for the future existence of private practices.

- The only current surveys and studies in the healthcare sector are ordered by the government and limit themselves to quantitative data. This is why a study on the quality factors that influence the choice of public or private clinics from the customer satisfaction standpoint is relevant and new in the domain.

1.4 Research topic

The research topic is centered on the quality factors that influence consumer satisfaction and drives them in choosing an institution from the private or public sector. This specific research topic is relevant because there seems to be a relation between the developing of the private health sector in Romania and the quality provided by both public and private sectors.

1.5 Research questions

The research questions are as follows:

*What are the quality factors that determine customer satisfaction concerning the two kinds of service?*

*What are the expectations and perceptions of patients concerning healthcare services in Romania?*

*Which is the most important element in healthcare services that influences consumer behavior?*

*What are the different elements of the decision process concerning healthcare service?*

*How strongly does price influence a decision between a public and a private healthcare service?*
1.6 Research objectives

The research objectives are complete and complex and aiming at understanding the whole process related to the topic. The objectives are:

- Determining the main characteristics that separate the public sector from the private.
- Determining expectations and perceptions, concerning the healthcare delivery system.
- Determining the main elements that influence consumers, in their choice of a public or private service.
- Analyzing the quality framework model for healthcare delivery services.
- Determining the percentage of patients satisfied with the service delivered for both private and public situations.

The research objectives are tied to the research questions, the most important objective being to determine the capital characteristics that differentiate the public healthcare sector from the private one. The other objectives derive from the leading objective. First, in order to determine the quality factors that differentiate the two kinds of practice, one must look at the expectations and the perceptions of patients and find the main element that influences choice, whether it’s price or accessibility or image, etc.

One subsequent objective is to assess the effectiveness of existent conceptual models and finally determine the percentage of satisfied patient in both public and private systems.

1.7 Research hypotheses

The research hypotheses are:

H1 – Public and private healthcare providers have different quality standards.

H2 - Patients choices are affected by hospital service quality.

H3 – Private healthcare services are perceived as better services than public ones.

H4 – Private healthcare services are perceived as more expensive.

H5 – Public healthcare services are expected to be poor, corrupt and limited of access.
1.8 Recipients of research

The recipients of the research will be:

- Dissertation supervisor
- Dublin Business School – MA. Marketing
- Policlinica Medisprof – Health clinic from Cluj-Napoca

1.9 Research limitations

Although this research is carefully prepared, it has its limitations. The research is limited by the fact that there is only one researcher who isn’t physically capable to cover a large number of medical units at a national scale. Moreover, the time available for this research is limited; otherwise it would be easier to expand the research at a bigger scale. There is also a deficient way of constructing a sample and an ample perspective due to out of date data (2011) and the limited access to private healthcare facilities databases.

Despite the fact that there is much literature to cover healthcare in general, there are only a few authors who make comparisons between the public and private sectors, thus developing frameworks that are not applicable in all systems.

Finally, the impact and importance of this research is not sure to be reached as desired without the support from the organizations and the participants involved.
2 LITERATURE REVIEW

2.1 Introduction

Marketing has considerably evolved in the past decades from a product-centered approach to service-consumer centered efforts. As western economies changed focus from industrial production, by outsourcing to developing countries, to service delivery, marketers have been forced to adapt to a new, more sophisticated consumer.

Therefore, traditional tools of constructing and evaluating products have evolved in order to assess the quality of services and customer/patient satisfaction (Oliver, 1981; Tucker 1985; Qu et al 2011). Theories on how to assess service quality from a customer perceptions point of view have emerged (Gronroos, 1984; Parasuraman et al. 1985, 1988, 1991; Zeithaml 1993) and have been enriched by frameworks to suit various domains with more complexity, such as healthcare (Conway and Willcocks 1997; Clow et al 1997; Badri et al 2009). Consequently, academic research has focused on customer satisfaction influencers and the different ways in which managers can benefit from the research and improve service performance.

Service management is an important part which influences service outcome and customer satisfaction. Gronroos (1990) has defined the six principles of service management and other authors such as Lanjananda and Patterson (2009) have gone forward in studying service determinants of consumer-oriented behavior.

Healthcare services have been given extensive attention from researchers in the past decades because of the interest popularized by politics and mass media. Research on vast and complex healthcare systems, such as the NHS in the UK, has been conducted and recommendations of new, effective architectures have been made (Towill and Christopher 2005).

However, analysis on other health systems, where the private sector is challenging the public sector is incipient. Academic researchers such as Lynch & Schuler (1990), Badri et al (2009) or Duggirala et al (2008) have conducted comparative studies from the
patient point of view even in developing countries, as these have been generally ignored (Andaleeb 2001).

2.2 Services marketing

As services have become the base of western economies, the need to concentrate marketing efforts in this area has become vital. Defining service characteristics is essential in the effort to understand and improve service in order to better respond to the customer demand.

“Put in the most simple terms, services are deeds, processes, and performances provided or coproduced by one entity or person for another entity or person” (Bitner 2009)

This definition is more complete than the previous ones (Kotler 1996) because it incorporates the idea that the customer could be brought in situations in which he would have to participate in the process of service delivery. Therefore he becomes a part of the service, influencing the outcome, as it applies to healthcare.

A service can be based around a product or a process, having tangible and intangible parts. However, the characteristics differentiating a service from a product are the following:

A. Intangibility: this is the basis of services differentiation. Services cannot be evaluated by the human senses as objects are evaluated, by touch, smell, taste, sound and sight. In the healthcare industry the patient cannot feel or touch the treatment, although he can be exposed to some physical evidence. Moreover, the patient isn’t in capacity to grasp the technical factors and understand the diagnosis.

B. Simultaneity: the production and consumption of service occur in the same period of time. This can make the customer part of the process and influence the outcome.

C. Heterogeneity: because the service consists of human actions and variables, the performance of a single service cannot be reproduced. In the case of medical
treatment, the treatment itself could be delivered in the same way, with minor
differences, but different patients would have different reactions.

D. Perishability: this refers to the fact that a service cannot be stored or returned. A
service is “consumed” only one time and cannot be reused or resold.

Therefore, the marketing mix of the services has also been enriched, compared to
products. The marketing mix of services has added three elements: People, Physical
evidence and Process. People are a very important part of the service because they
represent the company and service delivery relies on their performance. Physical
evidence or servicescape is the environment in which the services are performed and has
a significant influence on the customer. The process is represented by the actions which
deliver the service.

2.3 Services management

Traditional management theories are concentrated on productivity and economies
of scale, principles formed by industrialization. In this case, the focus of management
rests on the structure of the organization as well as on productivity and financial results.

In contrast, service management is much more flexible and takes less into
consideration the structure of the organization, concentrating on the process and the long
term outcome. As Gronroos (1990) states: “In managing service competition, the
complicated characteristics of services and the nature of service production and
consumption (e.g. the inseparability of production from consumption and the role of
customers and co-producers, as well as the broad interface between the service provider
and the customers) make the external efficiency of the business, i.e. customer satisfaction
with the operations of the organization, the focal point of management.”

Gronroos moves forward in defining the six principles of service management:

1) The profit equation and business logic – this first principle relies on
customer perception which ultimately drives profit.

2) Decision-making authority – this refers to the proximity between the
decision-making person and the customer, leaving only strategically
important decisions to the central management.
3) Organizational focus – the principle here is that the entire organization is structured and working in order to mobilize all resources in order to support front desk operations, the direct contact with the customer.

4) Supervisory control – management has to focus on the encouragement of employees and limit control procedures as much as possible.

5) Reward systems – the production of customer perceived quality has to be the focus of reward systems.

6) Measurement focus – the sixth principle states that although internal measurement criteria is often used, customer satisfaction with quality of service has to be the main method in measuring achievements.

Although Gronroos (1990) gives a complete representation of service management and its principles, he does this by contrasting them to the traditional industrial management strategies. This leads to an incomplete and perhaps outdated way of looking at service management and competition. A very important principle of service management today is the length of customer relationship and loyalty. The importance of length of relationship between the service provider and the customer must be recognized in a highly competitive environment. The length of relationship is a satisfaction measurement tool. If the customer is satisfied by the quality of service, he will return to the service provider.

In order to take service management further, Coulter and Coulter (2002) have conducted a research study that focuses on trust as a critical part of service relationship. The research was based on a premise of a relationship between the customer and an individual service representative. The study establishes that the characteristics of a salesperson or service representative that affect the establishment of trust are: competence, ability to customize solutions, promptness, reliability, empathy, politeness and perceived similarity between service representative and customer. However, Coulter and Coulter (2002) have conducted this study in a B to B (Business to Business) context therefore it cannot be applied to B to C (Business to Client) situations. Furthermore, there are no explanations to the random sample size and this questions the reliability and relevance of the results.
An important part of services management is organizational culture. Helms and Stern (2001) refer to culture as “beliefs about the common practices within the organization” while Carney (2011) completes this definition with ethical values comprising accountability, responsibility, trust and professional standards of care. Helms and Stern (2001) study on employee perception of organizational culture found significant differences in perception, influenced by age, gender and ethnicity of the employee. Lanjananda and Patterson (2009) went further with a study on determinants of consumer-oriented behavior in healthcare. The authors found that while basic personality has an impact, surface traits, powered by perception of service climate and commitment, are good predictors of consumer-oriented behavior. After undertaking a study on 50 healthcare professional managers in Ireland, Carney (2011) found that cultural influences such as excellence in delivering healthcare, ethical values, involvement, professionalism, value-for-money, cost of care, commitment to quality and strategic thinking were essential determinants in quality care delivery.

Furthermore, there are elements such as emotional labor that characterize work of health professionals, especially in departments like intensive care or cancer treatment. Sorensen and Iedema (2009) use this premise to undertake a study in Australia. This study found that the negative effects of emotional labor were not formally acknowledged and that there were no institutional mechanisms to support medical staff in this matter.

2.4 Services in healthcare

The health sector can be characterized by a wide-spread policy that sets the way health services should function: government-owned and tax financed. As Hanson and Berman (1998) state, a large number of countries have “established similar systems of peripheral clinics and health workers, integrated community centers, and a tiered system of public hospitals”. Hospitals are defined by national statistics in terms of number of beds and personnel, a very limiting and arbitrary approach.

Furthermore, government financing is done by assessment of hospital size and turnover, not based on performance. Therefore, a lot of attention is driven towards the public system; academics are making constant recommendations for improvement in terms of efficiency of cost and performance. Towill and Christopher (2005) propose an
analogy between healthcare delivery and commercial logistics in order to satisfy the need for balance between supply and demand in this sector. These authors propose new healthcare pipeline architecture, based on the variables of duration, time windows, volume, variability and variety (Figure 2)

Figure 2: Healthcare pipeline architecture model

At a later date, Towill and Parnaby (2008) concentrate efforts to suggest a new approach for the system, from a functional focus to a patient focus, all through appropriate management of resources and supply chain. Despite the efforts to reform the public healthcare system, barriers to change are still existent and hard to cross.

The private health care providers come as an alternative to the public system, growing rapidly in many countries. As Hanson and Berman (1998) say, there is the assumption that the private sector is developing by covering undeveloped areas of the market. The authors study the development of private health care in developing countries. They define private providers as those who are not controlled by the government, privately owned care facilities seeking profits. In fact, in many cases models are conforming to the public one because they rely on public financing. Income and socioeconomic variables such as private and social insurance and the nature of the medical system are influencing the development of the private sector.
In the analysis of the healthcare system, much emphasis has been put on the ways of assessing quality services rather than improvement of quality through theoretical conceptual models, aiming at a better level of understanding the customer perceptions and expectations and the ways of satisfying demand.

2.5 Service quality

As a good attempt to define service quality, Clow and Kurtz (1997) state that it is “the difference between the expectations a consumer had prior to a service encounter and the perceptions of the service received”

In another effort to define service quality, Gronroos (1984) concluded that the principal components were functional quality, technical quality and corporate image. On the other hand, SERVQUAL has been used on such a massive scale, dismissing other frameworks, that it has become synonym with service quality itself (Woodall, 2001). However, in some recent literature (Parasuraman and Grewal, 2000), service quality is a concept used mainly as the base of customer value, which acts as a key determinant of repurchase and customer loyalty. Woodall (2001) goes back and concentrates on service quality, putting forward the six sigma concept through the reference points that help define it (McClusky, 2000):

- Six Sigma: methodology for step reduction of defects to a target of 3.4/million opportunities.
- Process focus: six sigma aims to highlight process improvement opportunities through systematic measurement.
- Six Sigma goal: defect reduction leading to cost reduction
- Six Sigma stretch goal: customer satisfaction through perfect product delivery.

In short, Six Sigma is a concept that emphasizes defect reduction in the service process. The search for perfect service delivery is surely of great interest to marketers, but as Woodall (2001) suggests they should concentrate on the “restructuring of a refreshed, inclusive, and potentially more relevant model for service quality”. 

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2.5.1 Consumer expectations

“The most common operational definition of service quality in the services marketing literature is that it is the difference between the expectations a consumer had prior to a service encounter and the perceptions of the service received” (Clow et al, 1997). This definition is based on the idea that the consumers are satisfied with a service only if the service experience meets or exceeds their expectations (Bitner, 1990). These statements imply that service quality can be measured by measuring expectations.

Gronroos (1990) and Zeithaml (1993) each develop a model of consumer expectations in an effort to determine ways of measurement. Gronroos (1990) states that consumer expectations of service are influenced by company image. Therefore, a positive image will serve to the consumer as an excuse for poor performance and a negative image will be very difficult to overcome indifferent of service performance. In addition, Zeithaml (1993) proposes a model of customer expectations formed by four parts: expected service, desired service, adequate service and predicted service. In fact, this model makes direct reference to the zone of tolerance; the minimum level of service that a customer is willing to accept. The effectiveness and current reliability of these two models are put at doubt. Twenty year old premises might not apply today because of constant evolution of markets and customers.

Thus, Clow et al (1997) proposes a new, more recent, model of consumer expectations which combines the two models developed by Gronroos (1990) and Zeithaml (1993)(Figure 3). The authors test the combined model across four industries. Not only the model is reliable but also gives interesting data. The study reinforces Gronroos”s premise (1990) and finds that firm image is the strongest antecedent of consumer expectations. In other words, if consumer expectations are high, it is because there is a good image of the firm. Furthermore, the study finds that advertising is less important for services than for products. However, the authors fail to find the answer as to why advertising has no effect on the consumer”s image of a firm as well as what are the different image impacts between distinct industries.


2.6 Service quality in healthcare

Defining quality service in the healthcare industry is hard because of the complexity and characteristics of the service. Ferguson and Lim (2001) argue that quality in general is an “elusive and vaguely-used concept” while discussing clinical governance in healthcare. Parasuraman et al. (1985) argues that: quality of service is the gap between customer’s expectations and perception of service. This definition does not directly imply the fact that perception is a subjective opinion and does not take into consideration the fact that in health care the patient participates in the production of the service and so the quality may be affected by the patient’s actions.

Service quality is divided into two categories: technical quality and functional quality (Gronroos, 1984). The first refers to the accuracy of diagnoses and medical procedures. Furthermore, skills and expertise also integrate the technical part. Functional quality rests on the way in which the service is delivered. In the case of a hospital: the facilities, the quality of food, cleanliness, etc. Health is difficult to assess due to the fact that the patient cannot evaluate service because of lack of expertise in the area. This is
why the patients will base most of their evaluations on functional aspects of quality rather than technical. This is stated by Vandamme and Leunis (1993).

Donabedian (1966) is one of the first to write an academic paper in which he attempts to describe and evaluate the methods of assessing the quality of medical care of his time. He does this by looking only at the process encountered at a physician-patient level of interaction. In the article, the author does not deal with healthcare at a larger level, and it would not be needed because he is not trying to establish a set of evaluation criteria valid for all patients, instead he is concentrating on evaluating the methodology and indices of measurement in general (what to assess). Donabedian gives a basic definition of quality in healthcare after arguing that “the criteria of quality are nothing more than value judgments”. For Donabedian, quality is “a reflection of values and goals current in the medical care system and in the larger society if which it is a part”. This definition is not only outdated but also very ambiguous compared to the categorized Gronroos (1984) definition mentioned earlier.

In “Evaluating the quality of medical care” (1966), Donabedian lists a number of approaches to assessment. He states that the best way to measure quality in medical care is by using outcome (in terms of recovery, restoration of function and of survival) as a criterion, even if it has limitations (patient attitudes and satisfactions, social restoration, physical disability and rehabilitation can be difficult to measure). The author is promoting an academic way of assessment, leaving out patient input when considering quality and not proposing any model to measure quality besides the quantitative “medical care outcome”.

In contrast to Donabedian (1966) outdated and simplified theory, Lynch and Schuler (1990) propose a consumer-oriented approach in: “Consumer Evaluation of the Quality of Hospital Services from an Economics of Information Perspective”. Here, the authors rely on items from a study and apply these items to three hospital service factors: the search factor, the experience factor and the credence factor. The first factor was developed by Nelson (1974) while Zeithaml (1981) developed an applicable framework for the three factors. The research has a strong reliable method and finds that applying the economics of information theory as a framework is pertinent when analyzing how
consumers judge the quality of hospital services and that hospitals can be categorized according to the three factors.

The development of the SERVQUAL model by Parasuraman et al. (1985) provides marketers with valuable information in monitoring the service. However, this model was originally produced after analysis of financial services and is not adapted to the difficulties of assessing health.

Therefore, Conway and Willcocks (1997) adapted SERVQUAL to the healthcare context (Figure 4). This model is presented in other academic journals (Rashid and Jusoff, 2009) along with the SERVQUAL model as both valid way of assessing the service, describing the latter as being used in a number of studies in the health sector.

Figure 4: Healthcare quality assessment model

Vandamme and Leunis (1993) develop a multi-item scale for measuring hospital service quality. However, they conclude that the developed instrument may not apply to healthcare in general because of the size and relevance of their study.
Consequently, the conceptual model presented by Conway and Willcocks (1997) is the most adapted to healthcare delivery systems. The classic dimensions (Parasuraman et al. 1988) taken into consideration in terms of expectation are:

1. Reliability: the ability of performing the promised service
2. Tangibles: the facilities, equipment, personnel
3. Responsiveness: providing a service promptly
4. Assurance: the ability to provide trust and confidence
5. Empathy: attention provided to the needs of the customer

The following dimensions are considered adapted terms to the healthcare system:

2. Choice – related to consumer preferences
3. Information – requested by the consumer
4. Redress – service recovery when needed
5. Representation – representing the patient through an organism or organization

Conway and Willcocks (1997) integrate in the analysis the five gap model developed by Parasuraman et al. (1985) – Figure 5.
Figure 5: The Five Gap Model

- Gap 1 is the gap between consumer expectation and management perception. In this situation, managers overestimate or underestimate consumer wants.
- Gap 2 is the gap between management perception and the actual service specifications. In this case the service specifications can be vague and this creates a gap with the management.
• Gap 3 is the gap between quality specifications and the delivery of service. This can happen when specifications are good but the provider fails to deliver the service as demanded.

• Gap 4 is the gap between the service delivery and external communications. This occurs when information communicated to the customer creates an unrealistic image of the service leading to higher or lower customer expectation.

• Gap 5 is the gap between perceived service and expected service. This gap is depending on the previous gaps and cannot be closed until those demands are satisfied.

Furthermore, Conway and Willcocks (1997) identify a series of influencing factors outside the regular interaction: the level of perceived pain, patient preference and personality, socio-economic status, relatives, friends and acquaintances. These outside factors are difficult to identify and to measure but have an influence on consumer expectation. Decisively, patient satisfaction depends on how the expectations are met and on the efforts of the service provider to close the five gaps.

Although the Conway and Willcocks conceptual model (1997) may be considered outdated, some recent research and proposed frameworks are not as reliable. Duggirala, Rajendran and Anantharaman (2008) define seven dimensions of total quality service in healthcare “based on an extensive review of literature on service quality”. These authors give unsound arguments to support their claims and dismiss the five gap model and SERVQUAL by declaring that there are studies that find that the “existing scales were not well suited for use in examining patient satisfaction with medical encounters”. Not only have these authors dismissed well known and recognized frameworks but also they have created a framework that cannot be compared with past literature on the subject therefore can be considered irrelevant.

Nevertheless, there are reliable studies that show the importance of patients” views as means to show existing quality and possibilities for improvement. Badri et al (2009) conduct research on public hospital patients from the United Arab Emirates in the hope of validating their model (Figure 6) of characterization of healthcare quality in a developing country. In their effort to develop the right model, the authors first base their
theory on Gronroos (2000) service quality factors (technical, functional) and on Parasuraman et al. (1988) SERVQUAL to finally separate quality into three dimensions: care and process quality, information and involvement.

Figure 6: Healthcare quality assessment model (Badri 2008)

Badri et al (2008) developed the following variables:

- Healthcare quality
  - Tangibles and physical attributes;
  - Empathy and personal attention;
  - Competency, knowledge, reliability and trust; and
  - Professionalism and courtesy.

- Process and organization:
  - Availability and access to resources; and
  - Rules, regulations and administrative matters.

- Information:
  - Communication, involvement and information sharing; and
  - Communication during transition to home.
• Satisfaction:
  o General and overall satisfaction; and
  o Relative satisfaction

• Health-status:
  o Health status before admission; and
  o After discharge

The authors conclude that this model would be useful in benchmarking the hospitals from the same country and stress the fact that patients’ health services perceptions seem to have been ignored by healthcare providers in developing countries (Andaleeb, 2001). The criticisms that can be brought to this research is the size of data collected (244 questionnaires) and applicability to health systems in western countries.

2.7 Patient satisfaction in healthcare

It is debatable whether satisfaction is a process or an outcome (Yi 1990). Consumer satisfaction definitions have concentrated either on the evaluation process or a response to an evaluation process. Oliver (1981) defined satisfaction as “the summary psychological state resulting in when the emotion surrounding disconfirmed expectations is coupled with consumer’s prior feelings about the consumption experience”. This definition suggests that satisfaction is an emotional response.

Pascoe (1983) gives a more complete definition, which deals more closely with the healthcare environment and joins the two concepts presented above. Satisfaction is the “patients” emotional reaction to salient aspects of the context, process and the result of their experience” in the authors opinion. This definition could be more suitable in representing the complexity and subjectivism of patients” process evaluation in healthcare.

In an effort to demonstrate to the hospital professional staff the importance of patient satisfaction in relation to quality, Woodside et al (1989) conduct a study based on a general framework relating service quality, customer satisfaction and behavioral intention. In order to measure patient satisfaction and behavioral intention, the authors
adapt their original framework to each of the two hospitals and their particularities, cross-validating the models in the end.

Gill and White (2009) state that the customer’s perception of quality cannot be evaluated by measuring satisfaction because “the construct has little standardization, low reliability and uncertain validity”. Furthermore, the authors state that focus should be on measuring technical and functional quality and not on patient satisfaction. Frimpong et al. (2010), after undertaking a study on patient satisfaction find that variability of satisfaction is “engendered by the nature of quality and the degree of emphasis that providers tend to place on specific dimensions of a servicescape”.

Naidu (2009) contradicts previous statements by declaring that satisfaction in health care can be measured by using an approach that combines patient inputs and expert analysis. The author proposes a model (Figure 7) for this analysis, based on the SERVQUAL model and adding influencing factors and going as far as patient loyalty (Figure 4). Furthermore, Chaniotakis and Lymperopoulos (2009) study in detail the relation between quality, satisfaction and word-of-mouth through quality variables proposed by Parasuraman et al. (1991).

Finally, Naidu (2009) acknowledges that the multitude of variables in patient satisfaction makes it difficult to measure and that the proposed model may not be generalized because of cultural differences.
In what academic research is concerned, Tucker (1985) takes a particular approach to satisfaction in healthcare by considering the relationship between level of physician training and patient satisfaction.

The author emphasizes two concepts: the fact that it is very difficult for the patient to objectively assess the skills and competence of a physician as well as the fact that the patients are becoming more aware and demanding due to the media coverage of medical practice. The author then states that patient satisfaction is critical to success due to increasing competition in medical care.

Furthermore, Tucker (1985) goes as far as saying that the curricula of medical education should change to include the teaching of methods of obtaining patient satisfaction. In conclusion, the author is suggesting that physicians should learn marketing and marketing management in order to achieve patient satisfaction be successful.
The claims of this author are based on very unsure premises. First, the author does not have a clear sampling method, referring to the study population as “composed of patients”. Second, data collection techniques are unclear and the author has emotionally toned views when referring to results, stating that “responses were very positive”. Overall, this article is not reliable because of weak and unsound arguments.

Contrary to the previous research, a more recent and well-founded study has been published in the International Journal of Health Care Quality Assurance. In order to see whether patient satisfaction is related to a certain typology (demographics, age, income, and education), Qu, Platonova, Kennedy and Shewchuck (2011) conduct a study of “Primary care patient segmentation” in the US. Based on a large sample and an effective pre-tested questionnaire, the study identified four segments of population that had different patterns of responses for the variables of interest.

Furthermore, the results revealed that “more educated, affluent, and younger patients made up a subgroup that expressed dissatisfaction with all or at least some of the satisfaction –with –staff indicators. These results are very important because they show that healthcare service providers have to further increase their efforts to satisfy patients by creating appropriate strategies that would address different segments. The authors conclude that the ultimate goal of assessing patient satisfaction is to improve the quality of healthcare service delivery.
2.8 Conclusion

The available literature involving healthcare services provides the researcher with enough information for him to have a view of ensemble. The articles cover almost every aspect that could influence service quality, patient perceptions and expectations. They discuss service management and marketing, the particularities of healthcare services, service quality and finally arrive at patient satisfaction.

There are a number of models adapted and used to assess healthcare services. The first identified model is Parasuraman’s (1985) five gap model. The second identified model is also based on SERVQUAL and the author (Naidu, 2009) combines patient inputs and expert analysis and concerns satisfaction with a service. The third model has been developed recently by Badri et al (2009) and it evaluates healthcare quality in a developing country. This last framework is probably the most adapted to the actual research environment and could serve the researcher as a method of interpretation. Also, considering the relevance and effectiveness of the patient satisfaction segmentation survey undertaken by Qu, Platonova, Kennedy and Shewchuck (2011), it would be useful to take into account their questionnaire.

Finally, it is important to state that in healthcare, “practices have been influenced more by electoral and ideological considerations than by basic rules of managerial best practices” (Towill and Christopher, 2005). This statement can be applied to the vast majority of healthcare systems throughout the world. The area of interest is not a recent one but there are gaps in the academic literature which need to be closed by providing a deeper analysis into consumer behavior in this industry. This would be useful to managers and marketers in the healthcare sector as well.
3 RESEARCH METHODOLOGY

3.1 Research methods chapter introduction

The method by which the researcher will structure his work is significant because it outlines the framework which will be used for the research. It is essential to firstly define the main elements such as questions, objectives and hypotheses that will drive the research and secondly present the key aspects that will help conduct the research (philosophy, approach, strategy). Furthermore, the collection and analysis of data in a defined time horizon as well as the defined sample are of utmost importance. These essential components of research methodology will be presented in the chapter that follows.

3.1.1 Research questions

The research questions are as follows:

What are the quality factors that determine customer satisfaction concerning the two kinds of services?

What are the expectations and perceptions of patients concerning healthcare services in Romania?

Which is the most important element in healthcare services that influences consumer behavior?

What are the different elements of the decision process concerning healthcare service?

How strongly does price influence a decision between a public and a private healthcare service?
3.1.2 Research objectives

The research objectives are complete and complex and aiming at understanding the whole process related to the topic. The objectives are:

- Determining the main characteristics that separate the public sector from the private.
- Determining expectations and perceptions, concerning the healthcare delivery system.
- Determining the main elements that influence consumers, in their choice of a public or private service.
- Analyzing the quality framework models for healthcare delivery services.
- Determining the percentage of patients satisfied with the service delivered for both private and public situations.

3.1.3 Research hypotheses

The research hypotheses are:

H1 – Public and private healthcare providers have different quality standards.

H2 - Patients choices are affected by hospital service quality.

H3 – Private healthcare services are perceived as better services than public ones.

H4 – Private healthcare services are perceived as more expensive.

H5 – Public healthcare services are expected to be poor, corrupt and limited of access.
The research methodology is what assists the researcher in an effort to better clarify the construct of the research. The research onion (Figure 8) is the best way to clarify and approach the research. Developed by Saunders et al. (2007), the research onion details the steps one must follow through and react to in order to provide correct and relevant data collection and analysis.

**Figure 8: The research onion**

3.2 **Research philosophy**

The first layer of the onion is research philosophy. The philosophy adopted by the researcher is related to the assumptions on how one views the world. Furthermore, the research philosophy defines the rest of the research and has significant impact on the understanding the outcome of the research and the manner in which it will be perceived by others.

According to Saunders et al. (2012), there are three ways of regarding research philosophy: ontology, epistemology and axiology.
Ontology is the nature of reality. It raises questions about general assumptions on the way that the world functions. The two standpoints of ontology are objectivism and subjectivism. *Objectivism* deals with what is generally considered valid and accepted, independent of external influences. On the other hand, *subjectivism* deals with how the world is perceived by people and the way they think and assert reality. Therefore, the focus of the present research will rely on subjectivism; the perceptions and expectations of customers, patients or ex patients in the case of this research.

The research philosophies cannot be evaluated in terms of performance but only in terms of suitability. One philosophy may suit one kind of research but not another. This is why research philosophies must be presented and discussed before the researcher presents his choice. However, recently it has been said that the researcher must consider philosophies as continual dimensions instead of separate ones (Niglas 2010). Some researchers think that choosing a philosophy that guides their research is not adequate; in consequence they might be pragmatists.

*Pragmatism*

Pragmatism applies to the researchers which take into consideration only what can be put to practice. For them, the finality of research is what can be put into practice. Pragmatists either apply multiple methods to their research in order to have a complete picture or a conclusive, certain and solid data providing method.

Epistemology refers to acceptable knowledge in terms of study and has three approaches:

*Positivism*

Positivism is an approach best suited for the science researcher who is looking to observe reality and define generalized rules and cause to effect relations. In this case the researcher develops a hypotheses starting from a previous theory and observes the elements that lead to the creation of credible data. Another characteristic of this philosophy is that the researcher does not affect the research, the gathering of data being totally objective and certain. In this case, in order to avoid subjectivity the researcher will
most likely use a model that can be replicated. Moreover, emphasis is put on quantifiable data. This is why this particular philosophy is not suited for the present research.

Realism

Realism is another philosophical approach that is based on science. Realism, as opposed to idealism, starts from the idea that objects exist outside the human mind. There are two forms of realism: direct realism and critical realism. Direct realism rests on the idea that the human senses give an accurate image of the world. Critical realism argues that human experiences are defined by sensations, subjective perceptions of reality. The distinction between the two approaches to the realist philosophy can be made by saying that direct realism occurs before critical realism. Therefore, sensations come after the actual sense of an object. Ultimately, critical realism cannot give an objective view of the world because it is based on the fact that only part of the world is seen through the eyes of the researcher and so the rest is a result of the environmental influence.

The researcher cannot adopt this philosophy for the current study because it relies on human expectations and perceptions and is not a scientific experience therefore it doesn’t involve the concept of objects existing outside the human mind.

Interpretivism

Interpretivism is a philosophy that acknowledges the differences between humans and their role in the society. Contrary to positivism which is based on objectivity, interpretivism relies on subjectivity and is associated with qualitative research. It has its origins in phenomenology and symbolic interactionism. Phenomenology refers to the manner in which people view the world around them. As for symbolic interactionism, it invokes the permanent process of evaluating the social world by the individual.

Interpretivism is suited for researchers looking to assess subjective perceptions on performance, experiences and expectations of humans. The challenge here is to capture the subjective view of the world perceived by the participants and it is very appropriate for business research and marketing.
The present research is not a scientific one. Consequently, the researcher will adopt an interpretive approach to the study which is best suited for the topic, considering that subjective views of the health sector must be gathered from clients and no experimentation will be undergoing. This is the best choice in this case because the researcher is trying to assess consumer expectations and perception of service; the way the customers view the world around them. The views concerning the health system will be subjective and the researcher will not ask the participants to give general accepted views of the healthcare environment. Furthermore, the data collected will not be presented as such, it will be interpreted. These are the reasons why interpretivism is suited as a philosophy.

3.3 Research approach

The second layer of the onion refers to research approach. Saunders (2012) states that there can be three approaches to the research: deductive, inductive and abductive.

**Deductive**

Hussey and Hussey (1997) define the deductive approach as “a study in which a conceptual and theoretical structure is developed which is then tested by empirical observation; thus particular instances are deducted from general influences”. The process of deduction occurs when the conclusion can be derived logically from the facts presented. This approach is based on the premise that all the facts are true which leads to a true conclusion (Ketokivi and Mantere 2010). The current research cannot be based on this approach because it is not based on facts but on subjective consumer views that are interpreted by the researcher. The researcher hasn’t developed theories, only hypotheses. These hypotheses will be tested by the data collected and analyzed. However, the deductive approach is not suited for this study because it is not a “top-down” research where conclusions are drawn by logical reasoning.
**Inductive**

In contrast, the inductive approach does not claim that the facts and premises observed are true and therefore cannot guarantee a conclusion, leaving room for interpretation. Inductive reasoning has “bottom-up” logic, contrary to deductive reasoning. Here, the conclusion is based on the observations of the researcher. There is no verification of a theory but a building of one through observation and exploration of a phenomenon.

The inductive approach is best suited for this research because the conclusion is judged to be reinforced by the observations made. This is the adapted approach because the researcher is trying to respond to a hypothesis through a study of patient views and expectations concerning a service. Furthermore, an inductive approach is the best option for the current study because the researcher is not trying to test a theory but rather develop a probable conclusion based on collected data.

**Abductive**

The abductive approach derives from a “surprising fact”, which is actually a conclusion. Starting from here, a set of premises that is considered enough to explain the conclusion is outlined. Hence, conclusions are tested by the premises which derive from them. The abductive approach is indeed a combination between deduction and induction (Suddaby 2006). The researcher rejects this approach because the purpose of this study is to reveal consumer behavior and interpret the results, not to determine consumer behavior based on an already known fact.

**3.4 Research strategies**

The third layer in the research onion deals with strategies. The research strategy a researcher chooses must be adapted to the research question an objectives. The strategy is what links the philosophy and the choice of methods to collect and analyze the data. (Denzin and Lincoln 2005)
There are a number of research strategies:

- **Experiment**: the experiment strategy is best suited for scientific observation and is based on precision and rigor. Variables are used here to test hypotheses and they are compared in order to determine the existence of links between them. There are three experimental designs: classical experiments, quasi-experiments and within-subject designs.

- **Survey**: a survey implies the use of questionnaires and statistics. A survey usually answers questions such as “what”, “who”, “where”, “how much” and “how many”. The use of questionnaires is highly popular because it allows the collection of standardized data from a large population in an economical manner and because it allows comparison. This type of strategy gives the researcher more control and with the use of sampling, the gathering of representative data at low cost.

- **Archival research**: this strategy uses records and documents as principal sources of data. Archival research allows the researcher to outline an evolution over time based on documents. This way of conducting research is hard because of general lack of access to archives and databases.

- **Case study**: the case study makes an in-depth inquiry in an event or context. It is characterized by the use of multiple sources of information that can form a panoramic view of the event or context. Here, the researcher objectively studies and analyzes the event.

- **Ethnography**: this strategy is used in the study of groups and has its origins in anthropology. It has developed as the study of primitive cultures. There are three ethnographic strategies, described by Cunliffe (2010): Realist Ethnography, Impressionist or Interpretive Ethnography and Critical Ethnography.

- **Action research**: action research implies identifying organizational problems and solutions. It is defined as “research in action rather than research about action” (Coghlan and Brannick, 2010:4). Action research is in fact a process. It begins with context and purpose and goes through
several cycles and stages (diagnosing, planning, taking action, evaluating and so forth).

- **Grounded theory (Glaser and Strauss, 1967):** is used in developing theoretical explanations of social interaction, different processes and contexts. It was developed as a response to “extreme positivism” of social research. In this case the researcher collects and analyses data simultaneously while developing analytical codes in order to organize data into categories.

- **Narrative inquiry:** this research strategy refers to the way of collecting information by having a complete storyline rather than fragments of data. Narrative inquiry is generally used with small samples composed of representative individuals who can give interviews meaningful to the research. This strategy is very time-consuming and can mean a great difficulty in structure and cohesion of the research.

The present research will make use of survey strategy. In doing so, the research will give quantitative and qualitative data of the perceptions and degree of satisfaction of patients exposed to public and private health systems. By choosing the survey strategy, the costs of the research will be maintained to a minimum and the effectiveness will be increased through the use of questionnaires which allow data collection from a large population.

Furthermore, survey strategy gives the researcher more control over the research process and allows him to show different relationships between parameters. The survey strategy is consistent with this research which is descriptive and exploratory.

Indeed, the survey strategy has its advantages and disadvantages. The data can be collected with minimum cost and time but the analysis is time consuming. Moreover, survey strategy uses questions like “what”, “who”, “where”, “how much”, “how many” which are essential in order to answer the questions of this research. This strategy is suited for the current research because it allows the researcher to gather valuable information in a limited time span.
3.5 Research design choice

Research choices represent the fourth layer in the research onion (Saunders et al. 2008). Recently, Saunders et al. (2012) has enriched this layer by detailing the quantitative and qualitative aspects. The choices can be summarized by qualitative, quantitative and multi method:

Quantitative choice

Quantitative research is associated with positivism and uses very structured data collection techniques. It is also associated with a deductive approach, analyzing the data through statistical techniques. Zawawi (2007) argues that the quantitative approach is designed to ensure objectivity, generalisability and reliability.

Qualitative choice

The qualitative design choice is associated with interpretive philosophy and the inductive approach. Here the collection of data is not standardized as in the case of quantitative approaches. Qualitative research is traditionally used in social sciences and market research (Denzin 2005).

Multi-method choice

Contrary to the two mono-methods described above, the multi method research design can be characterized by saying that it is using more than one data collection technique, a combination of qualitative and quantitative. Furthermore, it is more complex than the mono-method research choice and is better for business and management research (Bryman 2006). The multi-method research provides richer information, giving to the researcher statistical data as well as qualitative data through in-depth interviews and focus groups.

This technique is the appropriate one to use in the research of factors that influence patients in their choice of healthcare in the public or private sector because it allows the two types of data to coexist and provide a richer analysis and interpretation. The multi method research represents the best choice by which the researcher will be able to address the research objectives and the research questions both of which demand
quantitative and qualitative answers. Through this design choice, the researcher will be able to gather information through a questionnaire as well as a focus group. This will not only enrich the information but allow the researcher to answer all research questions, which can’t be answered by quantitative choice only.

3.6 Research Time Horizons

Research time horizons, the fifth layer of the research onion relates to two types of studies: cross sectional studies and longitudinal studies.

Cross sectional studies are usually used to study particular phenomena at a particular time. The research is often constraint by time and longitudinal research cannot be conducted. This time horizon is associated with the survey strategy because this allows the researcher to acquire data quickly.

Longitudinal studies are implemented over a long period of time and are characterized by the study of change and development in the study subject. Longitudinal studies are better suited for doctorate degrees than for licenses or master degrees.

The researcher is compelled to choose a cross-sectional time horizon for this research as there is short time given for the gathering data. Data will be collected in a month’s time and this represents a short and punctual period of time. A cross sectional time horizon is best suited for this research because the researcher will not make repeated observations of a variable; instead study a phenomenon at one specific point in time.

3.7 Data Collection

The core of the onion is constructed of data, specifically the collection and analysis of data. The way the data is collected is very important because the tools and manners in which research is conducted are the factors on which reliable data stands upon.

3.7.1 Secondary Data Collection

Secondary data is generally large, detailed data composed of raw data or published summaries that a researcher cannot collect himself. The reasons for this are: lack of money, time and access. This data can be further analyzed and interpreted to fit the research currently conducted.
Most of secondary data can be found on the internet with a lot of ease. Secondary data such as surveys can be very useful in order to further determine the sample for example and in some cases answer research questions.

Secondary data can be quantitative or qualitative and can further be devised as raw data (with little or no process) or compiled data. Saunders et al (2012) divides secondary data into three subgroups – (Figure 9): documentary (text, non-text), survey-based (census, continuous and regular surveys, ad hoc surveys) and multiple-source (snap-shot, longitudinal):

Figure 9: Secondary data collection methods
In this research, different types of secondary data will be collected and used from all the three subgroups:

- **Documentary data**: organization patient databases and monthly reports as well as magazine articles.
- **Surveys**: country data from Euro stat (Healthcare expenditure), World Health Organization, Unicef, 2011 Romanian census (www.insee.ro), government annual sector reports (SAN 2011 – National Health Statistic) and organization surveys.
- **Multiple source**: snapshot data compiled from surveying companies as well as industry statistics and reports and European Union publications (www.europe-health-care.eu)

Secondary data is accessible, cheap and documentary data, surveys and multiple-source will add a richness of information to the research and will help the researcher further developing the methods for primary data.

### 3.7.2 Primary Qualitative Data Collection

Focus groups will be of utmost importance for the research and will provide great richness in information concerning the subject. Furthermore, focus groups are a good tool to use in exploratory studies (Cooper and Schindler 2008) and the advantages to this approach are coherent with the particularities of the research (Easterby-Smith et al. 2008; Jankowicz 2005):

- There are a large number of questions to be answered
- The questions are complex and open-ended
- The order and logic of questioning may need to be varied

There are however disadvantages to this approach and they are:

- Reliability or lack thereof because the results may not be reproduced (Easterby-Smith et al. 2008; Silverman 2007)
- Forms of bias – interviewer bias – where the interviewer’s comments influence the discussion
• Generalisability – whether the result will be applicable in other settings
• Validity – in order for the interview to be valid, the researcher must conduct it carefully and not lose the scope of the meeting.

Focus groups will allow the researcher to go in depth and pose open-ended questions, as opposed to the questionnaire which has closed-ended questions. Focus groups will be conducted with medical staff and management in order to identify existing gaps between management and physician perceptions of consumer expectations and expected service (the staff will need to have at least a 12 month experience in both private and public hospitals). Data collection in this case will be done through handwritten notes and through a recording device (audio). Hand-written notes will represent the hard data while audio recordings will provide richer information as to the context the opinion was given into, the tone, the conversation.

The researcher will follow the procedure for planning and conducting focus groups stated by Malhotra (2010):

• Clarify the research problem(s) and objectives
• Clarify the role of focus groups in fulfilling those objectives
• Specify the issues to be developed in the focus group
• Specify the target types of respondents to make up groups
• Specify the locations(s) to conduct the focus groups
• Recruit group members
• Run an experimental group
• Conduct the focus groups
• Analyze data and present findings

The researcher will establish a time and place with the participants and take their consent for recording the discussion (see appendix C) as well as demographic data (see appendix D). The focus group will be moderated by the researcher but it will not be restrictive in any way and the participants will be accorded equal time for discussion. The focus groups will be formed by 4-5 medical staff participants (with work experience in
the private and public sector) and duration of questions will be approximately 60 minutes, arriving at 90 minutes for the entire meeting.

Concerning the script of the focus group (see appendix E), the moderator will present an overview of the research (PowerPoint presentation), set the ground rules and proceed with the questions (opening questions, introductory questions, transition questions, key questions and ending questions).

The researcher has chosen to make the introduction to the research through a PowerPoint presentation because it will be easier for participants to visualize and will take the attention off the researcher himself who is overall inexperienced in conducting focus groups. The opening question is there to break the ice and get the researcher acquainted with the participants, make the feel at ease. The opening questions give a first impression of the perceptions of management and medical staff concerning patient expectations (Gap 1 in the Five Gap Model). The key questions address the perception concerning the determinants of the decision and the decision process as well as the quality factors that separate the public healthcare sector from the private one. These questions are made to determine staff and management perceptions over the patient expectations and show how things are done in the two systems. These questions will cover Gap 2, 3 and 4 of the model in an effort to have an exhaustive comprehension of the matter. The ending question calls for the participants to summarize their opinions. This question will force the participants to give a comprehensive overall view of their opinions and make them reevaluate, if necessary, their opinions.

The researcher has chosen this script because it is adapted to the Romanian environment. In Romania, there is no notion of focus group and in order to make the participants understand, the researcher has set ten to fifteen minutes for the presentation of the slides and the explanation of the purpose of the meeting. Furthermore, there are only ten main questions in the script because an abundant amount of information must be collected in approximately 60 minutes. For a group of 4-5 people, this means one minute to one minute and a half of speaking per person per question. This gives a small amount of time for each participant to engage in the discussion.
The researcher has set approximately one hour for the focus group questions, leaving a coffee break after 30 minutes because of the fact that the attention span of an adult is approximately 20 minutes and it is hard to keep the participants engaged throughout the entire meeting.

Finally, focus groups are a great way of gathering rich and valuable information concerning perceptions, expectations and overall opinions and degree of satisfaction, elements which are vital to this research. In this perspective the script and other details have been set to increase the effectiveness of the focus group.

3.7.3 Primary Quantitative Data Collection

Primary quantitative data will be collected through the survey method, based on a questionnaire. There is more than one type of questionnaire. Saunders (2012) reveals the following (Figure 10):

Figure 10: Types of questionnaires

The questionnaire will be interviewer-completed in most cases because this research deals with patients which may be admitted to hospitals and incapacitated. Moreover, the questionnaire uses technical terms which need be explained in most of the cases.

In designing the questionnaire, the researcher will follow the process described by Malhotra (2010):

- Specify the information needed
- Specify the survey administration method
- Determine the content of individual questions
• Design the question to overcome the respondent’s inability and unwillingness to answer
• Decide on the question structure
• Determine the question wording
• Arrange the questions in the proper order
• Identify the form an layout
• Reproduce the questionnaire
• Eliminate problems by pre-testing

The mode of administration will be in-home/in office and on location, face-to-face. The questionnaire design is important because the reliability and validity of the data depends on it. The questionnaire will comprise of close-ended questions (Fink, 2009) and multiple choice questions or forced-choice questions (deVaus, 2002). Close-ended questions will consist of quantity questions (ex: year of birth, number of visits), category questions (ex: first visit, once a week, etc.), ranking questions (no more than seven items – Bloomberg et al, 2008) and rating questions. The questionnaire will expand on no more than two pages in order to avoid participants from not answering questions because of impatience. Furthermore, because the questionnaire will be administered face to face, it will not have an introduction. The researcher will make an introduction verbally, which will save valuable time and involve the respondent even more.

The questionnaire will be structured in three parts: “general demographic data”, “the use of healthcare services” and “public healthcare and private healthcare services”. The first part will comprise of demographic data that will be linked to consumer behavior through following questions. The second part will have questions which will help the researcher understand how frequent the respondent uses healthcare services and the decision process as well as expectations. The third part refers to comparative questions between the public healthcare sector and the private one, ending in satisfaction questions.

The questionnaire has been designed in such a manner as to first introduce the reader to the subject of healthcare services in general and then refer to the opinions and behavior concerning these services. The design of the questions is made to guide the
respondent and leave not space for misunderstanding. There are a number of choices,
closed questions comparing the public and the private healthcare sectors and not leaving
the ability to choose both answers. Overall, the questions have been worded and designed
to assure answers to the researchers’ objectives and questions regarding the subject.

The first draft of the questionnaire (see appendix A) has 25 questions, worded in
English and the pre-test conducted on 10 people has shown that it is difficult to
understand the questions as the terms in ranking questions are too technical. Therefore,
the second draft (see appendix B) has been translated and modified in regard to the
wording of the questions and has simplified questions in order to be better understood
and easier to answer. The questions which were perceived as complex and technical were
set at a few questions distance and split into two questions. This has lead to a 27 item
questionnaire, expanding on two pages.

These questions will capture the behavior of patients as well as opinions and will
help rank and rate different items in healthcare as well as facilities.

3.7.4 Data Analysis

Data interpretation will be made through Sphinx. It will be presented and
described through charts and using statistics. Relationships and differences will also be
examined using statistics.

Qualitative data will be analyzed through conceptual models and frameworks
such as SERVQUAL or based on this tool. The data will be prepared by transcribing the
recordings from focus groups. Because the interviews will be conducted in Romanian, the
researcher will translate them in English. Qualitative data will be analyzed by the
researcher in an inductive manner.

3.8 Population and Sample

Sampling is essential in conducting research and provides a manageable size to
collect data from. Sampling is a good alternative to census (Saunders 2007) because it
would be impossible to survey the entire population, the research is under budget and
time constraints and the results need quick delivery. Collecting results from a sample
could make them less accurate than from a census but it is time and cost-effective. The
population on which the research will be conducted has to be clearly defined using elements, units, extent and time.

The research population will be as follows:

- **Elements:** healthcare services users who interact with the public and private sectors
- **Units:** 550 000 - 600 000 health insured people
- **Extent:** Cluj County, Romania
- **Time:** Mars 2013

### 3.8.1 Sampling frame

The sampling frame selected for the research refers to people within the Cluj County, healthcare insured, with access and prolonged experience in dealing with healthcare services. The sampling frame will be based on the number of insured people in the area which is approximately 550 000 - 600 000 people – over 300 000 coming from the urban area and the rest from the rural area (source: [www.insee.ro](http://www.insee.ro))

### 3.8.2 Sampling techniques

The sampling techniques available are divided into two types (Figure 11): probability sampling and non-probability sampling. (Saunders 2012)

*Figure 11: Sampling techniques*
Probability sampling (or representative sampling) is associated with a survey strategy. This technique is based on the idea that the researcher will estimate statistically the characteristics of the sample to the whole population. In this case, the techniques are simple, systematic, stratified and cluster. The researcher is not in position to use probability sampling because of the size of the population, a fact which will also have an impact on the size of the sample. Indeed, in order to have a margin of error of 1% on the population size described above, the researcher would have to undertake thousands of questionnaires, which is unrealistic to the time available and the financial possibilities.

Non-probability sampling implies that the cases selected from the population are not known. Non-probability sampling can be done by quota, purposively, by volunteering and hap hazardous.

The sampling technique chosen by the researcher is non-probability sampling because it is currently impossible to determine a sample based on the population information. The demographic data and other qualitative data is unavailable to the researcher as there is no research done by any authority on the characteristics of patients but rather on the number of cases annually, the number of admitted people and the number of patient each hospital has. This means that people with access and experience in healthcare will be selected over the period of time of the study. However, the sample will be purposive and thus homogenous. The people participating will be either patients or ex patients with the same characteristics, verified through the questionnaire itself. In addition, the questionnaires will be completed in medical facilities, so this is not hap hazardous sampling.

3.8.3 Sample size

Data collection and analysis skills will ultimately be more important than sample size (Patton 2002). Because the researcher has chosen no probability sampling, the group will not be representative to the population, but it will be homogenous. The researcher will undertake approximately 100 questionnaires on a sample which is composed of current patients, patient relatives and former patients which long experiences in the healthcare sector in both public and private cases. In this regard, oncology patients are a type which have long and regular experiences in both private and public sectors and are
able to better assess the quality of these services. The researcher will concentrate his efforts on obtaining relevant information from people who are able to provide rich insight into the subject of the research.

### 3.9 Ethical issues

While collecting data, there is more than one ethical issue that can arise. The research might be affected by broad social norms of and defensive behavior (Zikmund 2000). Ethical considerations are of great importance in this research because the population subject to this research may be put in embarrassing situations.

Firstly, the researcher must consider the rights of the participants and not harm or intrude in their privacy. Even in the situation where the researcher has a signed consent, the participant still has the right to refuse to answer to a question or withdraw from the research.

Secondly, the researcher must remain objective and not influence the answer of the respondent. Because data collection methods will be face to face, the researcher may be inclined to comment himself regarding a question and this might influence the response. Furthermore, the researcher has to be careful not to impose on people to answer questions they do not wish to answer and put the participant in a stressful situation.

Thirdly, in order to avoid any confidentiality and anonymity issues, the researcher will not ask for any names concerning the questionnaire and will have focus group participants sign an informed consent which will include a confidentiality agreement. The research will be conducted with the consent of all of those participating in the study and they will be debriefed concerning the collection and use of the data.

Finally, the researcher will conduct focus groups in respect of the social norm and the code of ethics in the medical field.
3.10 Limitations to the Research

Firstly, the limitations might be in the qualitative area as the researcher does not have much experience in conducting focus groups. Indeed, the difficulty of conducting and recording focus groups could have great impact on the validity of the research because of objective selection of relevant data. Subject error and observer bias are two of the risks that could compromise reliability. Furthermore, focus groups are a concept not developed in Romania and the participants might not understand the process and the purpose. This would make the participants speak off-topic and the focus group could lose its relevance. Another issue could be the acceptance of certain people to participate in a focus group with colleagues, superiors or strangers. The presence of a hierarchic superior, for example, could influence the answer given to a question and could make the answer invalid.

Secondly, quantitative limitations may arise because of limited time of research and representativity of the sample and therefore put in question the validity of quantitative data collected through the questionnaires. The number of questionnaires collected could also be too small. What is more, the number and complexity of questions could cause the respondent to lose interest and attention and not answer the questions correctly or at all. In addition, because the questionnaires will be completed face to face, this action will be time consuming, especially in cases where people are admitted to hospitals and incapable to complete the questionnaire themselves because of their condition.

Finally, the limitations of this research are those concerning the results which may not be representative due to the small sample and the time available. Therefore, the results of this research may not be reproduced to a wider scale because of lack of representativity.
4. DATA ANALYSIS AND FINDINGS

4.1 Introduction

This chapter presents the data analysis and findings. The data were collected in a manner as to provide responses to the objectives and hypotheses presented in the first chapter, the purpose of this dissertation. The main goals of this research were to determine the quality factors that differentiate the public healthcare system from the private one, find out what patients are expecting and what their perceptions are, determine their decision making and the degree of satisfaction with medical services.

In an effort to find answers to the objectives of this research, data were collected through a survey questionnaire and a focus group. The answers to the research questions and objectives are provided in this chapter which aims to demonstrate the link between theory and practice.

4.2 Quantitative data analysis

Quantitative data collection was made through a questionnaire designed for people using both public and private health services. In this section, statistical data will be presented through tables and charts for each question present in the questionnaire.

The questionnaire was administered during one month on the premises of two hospitals, the Cluj-Napoca Institute of Oncology and Medisprof Clinic, and the researcher was able to gather 91 questionnaires during that time. All 27 questions have 100% response rates except 4 rating questions that vary from 50 to 80 percent. These numbers attest the validity of this research.

The first part of the questionnaire contained three demographic questions. These questions referred to age, sex and origin (urban, rural).
The first question refers to the age of the participants (Table 1):

<table>
<thead>
<tr>
<th>AGE</th>
<th>Nr.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No answer</td>
<td>3</td>
<td>3.30%</td>
</tr>
<tr>
<td>Less than 20</td>
<td>1</td>
<td>1.10%</td>
</tr>
<tr>
<td>20 to 30</td>
<td>20</td>
<td>22.00%</td>
</tr>
<tr>
<td>30 to 40</td>
<td>22</td>
<td>24.20%</td>
</tr>
<tr>
<td>40 to 50</td>
<td>15</td>
<td>16.50%</td>
</tr>
<tr>
<td>50 to 60</td>
<td>11</td>
<td>12.10%</td>
</tr>
<tr>
<td>60 to 70</td>
<td>13</td>
<td>14.30%</td>
</tr>
<tr>
<td>70 and over</td>
<td>6</td>
<td>6.50%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>91</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 1: Respondent age

As we can see from this table and questionnaire answers, the age of the respondents varies from 18 years old to 78 years old, which is significant amplitude. Furthermore, the average of the sample is 43.67 years old and as the table shows, the majority of the respondents range from 30 to 40 years old. What is important to point out here is the relation between age and other variables such as frequency of use: Table 2 shows two distinctly colored categories of age, showing that the older (than the average) participants use healthcare services once a month and younger (than the average) use them every six months.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once a week</td>
<td>51</td>
</tr>
<tr>
<td>Once a month</td>
<td>54</td>
</tr>
<tr>
<td>A few times a</td>
<td>48</td>
</tr>
<tr>
<td>month</td>
<td></td>
</tr>
<tr>
<td>Every six months</td>
<td>34</td>
</tr>
<tr>
<td>A few times a year</td>
<td>38</td>
</tr>
<tr>
<td>AVERAGE</td>
<td>43</td>
</tr>
</tbody>
</table>

Table 2: Age-frequency cross-table
**Q2.** The second question referred to the sex of the participants:

Figure 12: Sex of respondents

This pie chart - Figure 12 - shows that the majority of participants were females. Indeed, from the total of 90 participants that stated their sex, 56 were females and 34 were males. However, there is no evidence that the sex of the participants has influenced any of the answers to the other questions.

**Q3.** The third question was posed concerning the area the participants came from in order to see if this had any influence on expectations and perceptions. The following chart - Figure 13 - shows information about the participants” origin area.

Figure 13: Area of respondents

The results show that the majority of participants (81%) came from an urban environment. The origin of participants is important because it correlates with the sampling frame in section 3.8 that shows that there are approximately 600 thousand people in Cluj County area of which more than half are urban and the others rural.
The second section of the questionnaire includes questions which refer to the general use of healthcare services.

**Q4.** The first one refers to access - Figure 14:

**Figure 14: Respondents evaluation of access**

73% of the participants’ evaluated accessibility to the healthcare system as facile while 27% put forward the difficulty. This is important because it helps to further determine if this is an important factor of perceived quality or it is taken for granted by the customers. When comparing urban respondents with rural respondents, it can be seen that only 18% of the respondents who answered “Yes” originated in the rural area.

**Q5.** The second question’s purpose was to determine whether all participants had experience in public and private services - Figure 15.

**Figure 15: Healthcare services use**
The answers to this question show that 97%, which means 88 participants, have had experience with both public and private medical services and therefore can assess the quality in both situations. Only one participant has said not to have experience in both domains. This is important because it verifies that the sample questioned is reliable and the participants have experience in both sectors and thus can evaluate them properly.

**Q6.** The next question evaluated the frequency of use of healthcare services and here the results were mixed:

**Figure 16: Healthcare services frequency of use**

From this doughnut chart - Figure 16 - it is apparent that 52.8% of the respondents visit a medical facility every six months or more frequently. Of these, 23.1% visit a medical facility with monthly frequency and 11% weekly, a number which is not negligible. Furthermore, the fact that the majority of participants to this questionnaire have visited frequently a medical establishment is an assurance of reliable insights.
**Q7.** The following question approaches the decision making in case of health services.

**Figure 17: Medical facility decision-makers**

![Chart](chart.png)

From previous experience, when you or your relatives are in need of medical care, who decides on the hospital?

- I usually decide: 24%
- I decide based on my physician’s advice: 21%
- My physician and I decide together: 30%
- My physician decides based on the information I give him: 4%
- My physician decides: 2%
- It depends on the situation: 19%

As one can see from this chart - Figure 17, the majority of respondents (43%) have declared that they decide themselves, either based on their physician’s advice or not. Other representative numbers are: in 30% of the cases the patient decides together with the physician or it simply depends on the situation (21%). In any case, the respondents answers show only 6% of the cases in which the physician decides, based on the information given by the patient or not. This information is important because this way the researcher will verify by means of the focus group if there is a gap in the perception and the patient is only under the impression that he decides by himself, based on his physician’s advice or together with his physician. Moreover, this decision depends on the age of the patient, as it is visible from the cross-chart below - Figure 18, the doctor takes the decision for older patients and younger patients take their own decisions.
Figure 18: Age-decision cross-graphic

- **Objective:** Determining the main elements that influence consumers, in their choice of a public or private service.

**Q8.** The succeeding question refers to the most important factors taken into consideration when choosing a healthcare service (consumer expectations) and it is a ranking question. The factors in this question represent an adaptation and simplification from the SERVQUAL model and the Clow et al (1997) model of consumer expectation.
It is visible from this chart - Figure 19 - that the most important factors are ranked as follows: the first is professionalism; the second is tangibles, the third is access, the fourth is the price and the fifth the image.

In a more detailed explanation, 78.43% of the respondents decided that professionalism was the most important decision factor, 31.37% decided that tangibles were second most important, 39.21% decided to put access in third place, 27.45% wanted price in fourth place and 45.09% taught that the image was the least important factor. The results to this question are important because they allow the researcher to see which the most important factors of decision are over a healthcare service.

- **Objective:** Determining the main elements that influence consumers, in their choice of a public or private service.
- **Hypothesis:** Patients choices are affected by hospital service quality.
Q9. The above pie chart (Figure 20) shows the results to a question which reveals that 95% of the respondents have greater expectations from a private healthcare service. This is important because it allows further interpretation in relation to the following questions. Indeed, the following questions explain why the patient has greater expectations concerning private services: because of: better quality (Q14 – 81%), better standards (Q15 – 88%), better equipment (Q16 – 92%), more professionalism (Q17 – 86%) better communication (Q18 – 90%), low corruption (Q20 – 5%) and overall a better image (Q21 – 86%).

Table 3 shows that expectations are higher for younger respondents and lower for the older average:

Table 3: Age-expectations cross-table

<table>
<thead>
<tr>
<th>Expectations</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>42.53</td>
</tr>
<tr>
<td>No</td>
<td>62.60</td>
</tr>
<tr>
<td>TOTAL</td>
<td>43.67</td>
</tr>
</tbody>
</table>

- Objective: Determining expectations concerning the healthcare delivery system.
**Q10.** The next question is in regard to consumer behavior and whether the consumer is prepared to pay a bribe in order to undertake surgery in a hospital.

**Figure 21: Use of bribery**

The numbers seen on this chart (Figure 21) attest to the fact that a third of the respondents are willing to pay a bribe if necessary in any situation, another third will pay a bribe only in the case of public hospitals and only 34% are not willing to pay a bribe. Only 1% of the respondents refused to answer, which represents a low number considering the sensitivity of the question. What can be gathered from this is that 31% of the patients are not willing to pay a bribe in the private medical units because they expect good service due to the perception of a more significant cost than in the public service.

**Q11.** The following question concerns patient expectations and has been constructed on the base of the adapted Conway and Willcocks (1997) SERVQUAL model, as it can be seen from the Figure 22 below (only eight of the factors have been used, leaving out the redress factor and the representation factor):
In this question the participants were asked to rate each factor with a number from 1 to 4, 1 being most important and 4 being the least important. As we can see from this column chart, 79.59% rated “Assurance” as the most important, followed by “Reliability” and “Tangibles” with a number of 69.38%. “Information” is the next most important factor, followed by “Empathy”, “Access” and “Responsiveness” and finally “Choice”.

From this we can conclude that “Assurance” – the ability to provide trust and confidence – is the most important factor that a patient expects from a service, a physician. Reliability refers to the ability of performing the promised service and this factor is also an important part of expected service. Third most important factor is “tangibles” – a term which refers to the facilities, the equipment, and the personnel. These answers are in coherence with the other questions (for example: the fourth question which referred to ease of access – 73% of the respondents, judge that they easily have access to medical care – explains why “Access” is not of great importance here).

- **Objective:** Determining expectations concerning the healthcare delivery system.
Q12. The next question is part of the third category in the questionnaire, which refers to the perceptions and behavior of patients regarding public and private healthcare.

Figure 23: Specialty treatment choice

This chart (Figure 23) exposes the fact that when put before a situation when specialty treatment is needed, 75% of the patients will choose a private practice. This is important because it shows patient preference towards a service, a fact explained by good image and perception of private service.

- **Hypothesis: Public healthcare services are expected to be poor, corrupt and limited of access.**
Figure 24: Healthcare differences

Is there a significant difference between the services in the public sector and the ones in the private sector?.

<table>
<thead>
<tr>
<th></th>
<th>No answer</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>2%</td>
<td>90%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Q13. As the Figure 24 shows, there is a significant difference between the two kinds of service, a statement strengthened by more than 90% of the respondents. This is important because although it seems that the personnel working in private facilities has originated in the public healthcare services; the customers have a perception of a completely different service.
**Q14.** The next question addresses the perceptions of consumers regarding the quality of medical services - Figure 25:

*Figure 25: Medical services quality perceptions*

The numbers supporting this chart are the following: a majority of 48.64% of the sample agrees that public healthcare services are of reasonable quality while the ones evaluating it as poor and awful represent a number of 44.59%. This is an immense gap compared to the private services that are perceived by 81.07% as good and excellent combined.

- **Objective:** Determining perceptions concerning the healthcare delivery system.
- **Hypothesis:** Private healthcare services are perceived as better services than public ones.
Q15. The following chart (Figure 26) is in relation to the question of different perception over the application of quality standards:

**Figure 26: Quality standards perceptions**

Do you think that the quality standards are applied differently in the public healthcare sector and the private one?

- 88% said Yes
- 11% said No
- 1% did not answer

Here, an overwhelming 88% perceived different standards of quality applied between the public sector and the private one.

✓ **Hypothesis:** Public and private healthcare providers have different quality standards.
Q16. Figure 27 shows how access to equipment and conditions is perceived in public and private medical facilities. 92% of the sample adhere to the statement that private healthcare facilities provide better equipment and conditions than the public facilities. This is important because it verifies patient expectations.

Figure 27: Access to equipment and conditions

![Bar chart showing where access to better equipment and conditions is perceived: 92% in private hospitals, 8% in public hospitals.]

✓ Hypothesis: Private healthcare services are perceived as better services than public ones.

Figure 28: Medical staff professionalism

![Pie chart showing the percentage of respondents who perceived medical staff more professional in public and private healthcare: 86% did not answer, 8% in public healthcare, 6% in private healthcare.]

From your own experience, the personnel has more professionalism:
Q17. Figure 28 displays an interesting perception that a large majority (86%) of patients has. The patients perceive that the personnel manifest greater professionalism in private healthcare than in public healthcare although in reality, the personnel in the private sector originate from the public one. There is only a small portion of the staff that hasn’t professed in the public sector and all of them have at least done 3 years of residency in the public sector, where the medicine graduates are obliged to finish their studies. (in Romania, the residency varies from 3 to 5 years, depending on specialization).

✓ Hypothesis: Private healthcare services are perceived as better services than public ones.

Figure 29: Staff-patient communication

In your opinion, in which situation does the personnel communicate better, to your understanding?

Q18. The above pie chart (Figure 29) attests to the fact that 90% of the patients have an image of personnel better communicating to their understanding in private hospitals than in public ones. This is due to the different time management in the two systems. While in public healthcare there are no fixed patient-doctor appointments and the patient is just set to see the doctor based on a set day, in private healthcare the doctors have appointments and can take their time in explaining to the patient the diagnosis, the treatment he is going to follow and so on.
Hypothesis: Private healthcare services are perceived as better services than public ones.

Figure 30: Medical services cost perceptions

Please evaluate the price of medical services in the following situations:

- Expensive
- Fair
- Good value for money
- Cheap

<table>
<thead>
<tr>
<th>Situation</th>
<th>Public healthcare</th>
<th>Private healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expensive</td>
<td>25.37%</td>
<td>36.86%</td>
</tr>
<tr>
<td>Fair</td>
<td>53.73%</td>
<td>7.46%</td>
</tr>
<tr>
<td>Good value for money</td>
<td>32.83%</td>
<td>19.40%</td>
</tr>
<tr>
<td>Cheap</td>
<td>34.32%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Q19: Figure 30 above shows the perception over price that the consumers have. While both public and private healthcare services are perceived as expensive by approximately 26% of the sample, only in the case of private services can there be observed a “fair” price evaluation. Moreover, public healthcare services are perceived as cheap, despite the fact that it is not the case as Romanian employees pay 5.5% of their salary monthly as health contributions.

Hypothesis: Private healthcare services are perceived as more expensive.
Q20. The matter of the price brings the next question, which regards corruption. This question is connected to Q10, concerning bribery.

The results (Figure 31) show clearly the public healthcare system as being more corrupt than the private one. This should affect the results to the question above but apparently corruption is not seen as cost in the eye of the consumer.

✔ Hypothesis: Public healthcare services are expected to be poor, corrupt and limited of access.
Q21. The next question (Figure 32) concerns the image that the two kinds of service confer to the consumer.

Figure 32: Image perception

![Pie chart showing image perception](image)

Apparently, the consumer perception of image is better regarding the private sector. A representative number – 86% - has stated that they have a better image of private healthcare services. Furthermore, Table 4 shows that the image is related to the age of the patient as younger respondents have a better image of private services than older ones:

Table 4: Age-image cross-table

<table>
<thead>
<tr>
<th>Image</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public healthcare services</td>
<td>49.20</td>
</tr>
<tr>
<td>Private healthcare services</td>
<td>41.48</td>
</tr>
<tr>
<td>TOTAL</td>
<td>43.67</td>
</tr>
</tbody>
</table>

In order to show that image is the strongest influencer of consumer expectations, Table 5 stands as proof that the respondents who have a good image of private healthcare services, also have greater expectations from this service:

Table 5: Image-expectations cross-table

<table>
<thead>
<tr>
<th>Image</th>
<th>Expectations</th>
<th>YES</th>
<th>NO</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public healthcare services</td>
<td></td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Private healthcare services</td>
<td></td>
<td>76</td>
<td>2</td>
<td>78</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>79</td>
<td>4</td>
<td>83</td>
</tr>
</tbody>
</table>
In addition, cross-tabulations show that the respondents who have a better image of private healthcare services consider that these services have more professionalism, better equipment, better communication and less corruption.

✓ **Hypothesis: Private healthcare services are perceived as better services than public ones.**

Q22. The next question (Figure 33) is closely related to the one above. It investigates the influencers of image in the mind of the consumer.

![Figure 33: Image perception influencing factors](image)

The factor that influence the most the image that consumers have of healthcare services are the tangibles (48%), followed by word of mouth (26%), price and advertising (13%). From the data presented here and in the chart above we can conclude that the tangible quality of services is poor in the public healthcare sector. Furthermore, this data confirms the survey presented by Clow et al (1997) in the Literature Review Chapter and their model. The results confirm that advertising is less important than word of mouth and tangibles which have direct impact of consumer expectations. Figure 34 shows that these image influencers are tied to the age of the respondents. Where tangibles are a main influencer to the general population, price is more important to older patients:
The next two questions are rating questions and they reveal data about the patient perception of service.

The first one is in relation to the perception of cost:

**Q23.** “For the following statement, please choose the answer that matches your view most closely.”

Figure 35: Private hospital cost perception
This chart (Figure 35) shows that the majority, represented by a percentage of 33%, agrees with the fact that services in a private clinic are more expensive than in a public hospital. This number is reinforced by another quarter of the respondents that tend to agree with the statement.

✓ Hypothesis: Private healthcare services are perceived as more expensive.

Q24. The second question is also a statement question:

Figure 36: Private healthcare access perceptions

From the data presented in Figure 36, we can conclude that the 59% of respondents that agree with this statement correspond with the 58% of the previous question (The participants that agree combined with the participants that tend to agree). Therefore, it is safe to say that even if private services are costly, they are more accessible while public services are perceived as cheap but of more difficult access.

✓ Hypothesis: Public healthcare services are expected to be poor, corrupt and limited of access.

The next three questions investigate the degree of satisfaction and the main quality factors that determine this satisfaction in the mind of the consumer. The integrating of the results of these questions cannot be put into a model such as the one presented by Naidu (2009) because here, the researcher does not benefit from the necessary information for
the model to be tested. Furthermore, as the author states, if tested, the model could be unreliable because of cultural differences.

The first question interrogates the consumer in relation to the degree of satisfaction concerning the public healthcare services - Figure 37; the second question refers to the degree of satisfaction with the private healthcare services and the last question tries to reveal which factors are most important in making a customer satisfied with the Romanian healthcare system.

Figure 37: Satisfaction with public healthcare services

Q25. The radar chart above shows that the majority of patients are satisfied with public healthcare services to some extent while 12% declare to be satisfied to a quite small extent, more than 15% to a small extent and 10% not at all.

✓ Objective: Determining the percentage of patients satisfied with the service delivered for both private and public situations.

Q26. Contrary to the result shown here above, the numbers from the second question concerning satisfaction reveal a totally different reality - Figure 38. Here, the arrow is pointing in the other direction. 52% of the respondents are satisfied with private services to a quite large extent.
In order to see how this decision is influenced, the researcher looked for determinants and discovered that old age is connected with low satisfaction with private facilities - Table 6.

Table 6: Age-satisfaction cross-table

<table>
<thead>
<tr>
<th>Satisfaction with private services</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>To a large extent</td>
<td>45</td>
</tr>
<tr>
<td>To a quite large extent</td>
<td>41</td>
</tr>
<tr>
<td>To some extent</td>
<td>45</td>
</tr>
<tr>
<td>To a quite small extent</td>
<td>71</td>
</tr>
<tr>
<td>To a small extent</td>
<td>71</td>
</tr>
<tr>
<td>Not at all</td>
<td>71</td>
</tr>
<tr>
<td>AVERAGE</td>
<td>43</td>
</tr>
</tbody>
</table>

- **Objective:** Determining the percentage of patients satisfied with the service delivered for both private and public situations.
**Q27.** The last question (Figure 39: Satisfaction factors) aims to reveal the quality factors that influence on customer satisfaction with healthcare services.

**Figure 39: Satisfaction factors**

These numbers correspond almost perfectly with those presented in the previous question concerning expectations. The only shift noticeable is between reliability and assurance. Where assurance was the most important factor in the expectations, reliability and tangibles are the two most important, that make the customer satisfied with the service.
4.3 Qualitative data analysis

As stated in the “research approach” section of the Research Methodology chapter, the researcher will use an inductive approach to qualitative data analysis. Furthermore, the researcher has chosen the critical discourse analysis approach. In this regard, the researcher will present the data collected from the focus group in a synthetic manner with a conclusion attached to every response.

The qualitative data of this research consists of a focus group conducted on the premises of the MEDISPROF clinic. The focus group was held on the 23 of Mars at 14:00 PM and lasted one hour and ten minutes.

The focus group was able to contribute to the subject of this research and enrich the information, giving insight into the works of the healthcare systems, both private and public. The focus group was composed of four participants. The demographic data that each participant was asked to complete involved sex, age, confirmation of practice in public and private healthcare systems, medical specialty, experience and the average number of consultations per month.

The demographic data shows that the participants consisted of two women and two men, their age ranging from over 20 to 50 years old. All the participants had medical backgrounds and three of them were still in practice while one had become manager of the MEDISPROF clinic. The specialties varied from oncology (two of the physicians) to clinical psychology, to occupational medicine. Only the psychologist, the youngest, had less than five years experience. One oncologist had between five and ten years experience while the other two participants had more than ten years experience. Overall, the participants could attest to having more than ten new patients a month. This data about the participants strengthens the validity of this focus group and was essential to verify and put forward in order to show reliability.

The discussion commenced with a presentation of the subject of research and the explanation of its importance. After explaining the rules to the participants, the researcher presented to the group the Five Gap Model which showed the objective of the meeting that was to investigate in detail the first gap (the difference between the perception of
management and staff in the services over what the customer expects and the actual service expectations of the customer).

After this short presentation, the moderator started with an introductory question, asking the participants to say where they would like to go on vacation. This question made all the members participate and set themselves at ease.

4.3.1 Critical Discourse Analysis

Discourse analysis is defined by Saunders (2012) as “the analysis of language used by individuals in specific social contexts”. Critical discourse analysis is the assumption that individuals not only transmit the sense of words but “reproduce or challenge” a social belief. Based on this premises, the researcher will now make an analysis of the focus group detailed in the appendix F.

Context: the focus group took place in the meeting room of the Medisprof clinic. The discussion involved recent and senior staff of equal and higher hierarchical ranks. The purpose of the discussion was completing the image of the Romanian health system and look at the gap between management and staff perceptions and consumer expectations.

Discourse: while the discourse was rather free and everyone spoke at a turn, the senior physician had more presence and took the work more often. Overall, the researcher got different views over questions and that enriched the information.

The opening questions concerned the patient expectations. Here, while the senior physician said that the patient expects too much, the younger member of the team explained that the patient expected empathy, professionalism and communication. All members came in accord when the word “promptness” was said. The researcher can conclude from this that physicians with different experience have different general perceptions. In addition, younger staff will adhere to the opinion of a senior member when declaring something in front of a third party. The same is valid for hierarchical superiority.

The answers to the key questions were given mostly by the two senior staff members while the younger members adhered to their opinions. However, the younger
staff completed the statements by giving pertinent answers. In regard to the question referring to the factors that determine the patients to choose a certain service, the younger female staff said that agreeable reception, trust and tangibles were important. Furthermore, the answers to the fifth question were led by the senior physician and the management representative while the others confirmed these answers. They said that the main element is corruption and gave reasons for it. The sixth question had unanimous answers. Participants to the focus group stated that private services are clearly better, except for the personnel which is basically the same. The seventh question concerned price and here, the doctors answered that the private services are viewed as more expensive although they are not. Public services, they said, are more expensive because there, the patient has to pay a bribe. Moreover, medical staff believes what makes patients satisfied with a service is care outcome, cost and courtesy.

Critically assessing this focus group, the researcher has to mention that senior staff led the discussion; responses to some questions might therefore be biased. What is more, the focus group was a completely new way of discussing to the participants and they drifted often from the questions, wanting to make known their opinions before the others. This leads to the conclusion that internal communication is badly done. The participants were at ease with each other and they were sincere, fact which can be derived from their speech.

Finally, this approach was not only new to the staff but unexpected in a way that answers can be perceived as guesses and not something that was well thought through. This gives away a manner of thinking which is not client-centered but simply work-centered and self-centered. While in western countries private healthcare has developed not only thanks to presenting an alternative to public healthcare (but giving an added value and a promise to the customer), in Romania private healthcare represents only an alternative and its main policies can be identified with “production” policies. In other words, the patient is viewed as a product that brings benefit, his wants and expectations being left on a second shelf.
5. CONCLUSIONS AND RECOMMENDATIONS

This chapter will present the conclusions of this paper based on primary research. It will point out in what way the findings clarify the concepts raised in the Literature Review Chapter. It will also link findings with the research questions, objectives and hypotheses. However, as Saunders (2012) states “This chapter should not be used to present any new material and should be a conclusion to the whole project (not just the research findings). Finally, in this chapter there will be recommendations.

5.1 Conclusions

In order to formulate pertinent conclusions, the researcher must link research objectives and primary research. The objectives for this research have been set:

- Determining the main characteristics that separate the public sector from the private.
- Determining expectations and perceptions, concerning the healthcare delivery system.
- Determining the main elements that influence consumers, in their choice of a public or private service.
- Analyzing the quality framework models for healthcare delivery services.
- Determining the percentage of patients satisfied with the service delivered for both private and public situations.

5.1.1 Objective A:

As presented in the literature review, there is more than one service quality definition and characteristics. While Gronroos (1984) put forward technical quality, functional quality and company image, Parasuraman et al (1985) developed the SERVQUAL model, which has become almost synonymous with service quality. Based on items from the SERVQUAL model and adapted by Conway and Willcocks (1997), the researcher has chosen to find the characteristics that separate two sectors of healthcare from the patient point of view. Thus, the researcher based his study on patient expectations, perception and degree of satisfaction in order to find out what separates the
public healthcare sector from the private healthcare sector in Romania. The findings show that there are two elements that make a separation between the sectors: internal policies and patient behavior regarding the two sectors.

First, the focus group findings show that the public healthcare system is affected by corruption and delivers bad service due to lack of funding, lack of positions for doctors and bad management. Indeed, the patient has to adapt to the service and not the other way around. Institutionalized corruption in the public sector is the main element which differentiates it from the private sector.

Second, patient behavior towards the two services is strongly affected by the image they project, a factor which also influences their expectations. The findings show that while an average of 54 years old patients are more frequent users (once a month), they have less high expectations from a private service (62 years old average) due to a better image of the public. What is more, older patients are less satisfied with private healthcare services and more satisfied with public healthcare services, which is why they choose to go to a public facility over a private one. This is due to generally low expectations from services that older customers have.

5.1.2 Objective B

The literature review chapter shows that one of the most adapted models in determining expectations is the one developed by Clow and Kurtz (1997) which combines the two models developed by Gronroos (1990) and Zeithaml (1993). The validity of this model has been proven by the findings of this research: there is a strong correlation between consumer expectations and image. For example, in the case of private healthcare services, 95% of people have higher expectations due to a better image (86%) of private services. This image is mainly influenced by tangibles (48%).

As far as patient perceptions of service are concerned it is as said in the literature review chapter: there is a particular difficulty in assessing health because of lack of patient expertise in the area. This is why the patients will base most of their evaluations on functional aspects of quality rather than technical (Vandamme and Leunis 1993). Thus, the findings show that perceptions of healthcare services are strongly influenced by
expectations (assurance – 18.7%, reliability – 15.2%, tangibles – 17.5%) which are of functional nature. Indeed, the only perception concerning technical quality is that of more professionalism (86% of respondents) in the private healthcare services, a factor which is evaluated by the patient through the human qualities that a physician displays rather than accuracy of diagnosis.

Overall, the private healthcare system is perceived as being more qualitative in many aspects than the public healthcare system, a fact which is reinforced by the testimonies of the focus group members who give rich insight into how the systems work. This is not surprising to the researcher as the private sector has shown better services in many industries.

Finally, the gap between consumer expectations and management and staff perceptions of consumer expectations is of utmost importance because it shows where the actual problem in the system is. Furthermore, there are no efforts seen in this direction, neither is there a will to change this fact and close the gap.

5.1.3 Objective C

This objective cannot be directly connected to the literature because they are particularities of the Romanian consumer behavior. The most important elements that influence consumers’ choice of a health service are: professionalism (78.43%), tangibles (31.37%) and access (39.21%). The researcher has to be critical about these factors because professionalism for example cannot be taken in its strict sense but rather in the sense of physician reputation and care outcome. Furthermore, tangibles are the most important factor influencing image (48%), therefore the researcher concludes that image is another important decision factor. Price is an important factor for older patients (47 years old), which is surprising because this is normally a period when people are economically viable.

In concluding, two profiles of the Romanian patients can be done: a younger patient is not as interested in cost and because he has higher expectations and better image of a private practice, he will choose the latter over a public hospital. Contrary to a young
patient, an older patient will choose a less expensive, public hospital from which he expects less and of which he has a better image.

5.1.4 Objective D
This objective refers to the conceptual models described in the literature review chapter. An adaptation of SERVQUAL by Conway and Willcocks (1997) is the first to be mentioned. The researcher used eight items from this 10 item adaptation and showed it was valid although hard to put into questions and assessed by a population uneducated in completing service quality surveys. The SERVQUAL model remains, however, the best tool in service quality analysis along with the Five Gap Model. The Five Gap Model can be applied in healthcare but, as this is a domain of much complexity, has to be completed with influencing factors such as patient health state before and after service (expected and perceived service). Additionally, perceived service should take into consideration functional quality only, because of the lack of expertise of the patient in the medical field.

Another model used by the researcher in designing questions and stating relationships between findings is the expectations model developed by Clow and Kurtz (1997) which combines the two models developed by Gronroos (1990) and Zeithaml (1993). This model showed not only that it is reliable and applicable in the Romanian healthcare context is but also useful in comparing two systems. Because it is complex it may be used to analyze varied industries.

The model developed by Badri et al (2009) is pertinent but has no real application here because of lack of information from secondary research. Secondary data is very scarce and the only data existent from independent sources such as GFK Survey is ordered by the biggest private hospital network and deals with general trends. Consequently, the researcher does not dispose of necessary information concerning the process in order to integrate primary research into this framework.

5.1.5 Objective E
The researcher has reached this objective and the findings give away the insatisfaction of patients with the public healthcare system and their satisfaction with the private services. Satisfaction is reached when expectations are met with perceptions of
service. In other words, the patient is satisfied with a medical service when he “gets what he expects”.

In the case of private practices, 95% of respondents who have higher expectations are situated in the average of 43 years old. 52% of these respondents are satisfied to a quite large extent and 30% to a large extent, which means private healthcare service providers project a truthful image of themselves and make realistic promises that they tend to deliver.

In the case of public practices, 50% of the respondents are satisfied to some extent while the other representative numbers indicate even less satisfaction. We have to take into consideration that expectations are already low concerning these services. The researcher arrives to the conclusion that public healthcare services make unrealistic promises through official representatives, and ultimately the hidden costs, the corruption and the lack of reliability makes the patients who already expect little, unsatisfied.

5.2 Recommendations

Finding out which quality factors differentiate health services in public and private sectors from the customer satisfaction stand point is important not only to the researcher but also to the actors in the industry. This research can provide rich insight to public and private healthcare facilities management.

First, public management should change their policies in respect to the patient expectations and offer better services in order to remain competitive. Indeed, the private sector has largely developed the past five years not only due to restructuring in the public sector but also the offering of better service. Public hospital managers should concentrate their efforts to limit corruption at a doctor-patient level and aim for prevention of disease instead of late treatment, a factor which increases cost to the public sector. In other words, the public sector should concentrate on educating the general population to the behavior they should have in regard to healthcare services and screen the patients regularly as to prevent disease and give pertinent diagnosis.

Second, private healthcare management offers better services than the public sector and has a competitive advantage, that of the objective of profit through efficiency.
However, private facilities management should convert from their “production” policies to service policies. In other words, managers have to stop marketing services as products and take into consideration the view of the customer. Specifically, managers should stop investing in advertising for healthcare services, a fact which has been shown to be almost useless in influencing image in this domain.

Third, patients should educate themselves to the idea that they are the ones who have the power and demand better services. The Romanian mentality is almost the contrary to what a medical service means. For example, the doctor thinks in the optics of “I am doing this patient a service, he should pay me a bribe” instead of “I need to help this patient, and he needs my expertise”.

5.2.1 Recommendations for future research

For of future research in the healthcare domain, the researcher can recommend that the basic qualitative and quantitative research be made.

First, a certain amount of bureaucracy must be put in place at a national level, allowing state and private organisms to get information about the number of patients admitted, their diagnosis and their origin through a complete database. This would create data that would be useful in defining the basic needs of patients. For example, knowing the county of origin of the patient could be used in asking questions such as: how many kilometers has this person traveled? Why? Would there be use for a treatment center of a certain disease there? These are basic questions that need answers but for the moment the patients follow the offer, not the healthcare facilities the demand.

Second, qualitative data has to be gathered to a centralized system that would enable a researcher in defining segments of population and their needs. Patient qualitative data should be gathered through a questionnaire with both closed and open-ended questions that collect data both structured and unstructured.

Furthermore, while completing a study like the current one, a researcher should take into consideration the particularities of the Romanian culture. The fact that the majority of the population is unused to qualitative research implies that a certain basic approach is necessary and the complexity of questions and objectives should be kept to a minimum.
Future research should aim for more general objectives concerning the process design of healthcare services in Romania and the general perceptions of customers and their desired service.
6. REFLECTIONS ON LEARNING AND SKILL DEVELOPMENT

This chapter concerns self-reflections over how the experience has made the researcher develop his personal learning, what can be concluded from the experience and how the learning will be used from this experience.

6.1 Reflections on learning

Personal learning is strictly tied to the learning cycle and styles. Keefe (1979) defines learning styles as the “composite of characteristic cognitive, affective, and physiological factors that serve as relatively stable indicators of how a learner perceives, interacts with, and responds to the learning environment.” However, all the present theories on this matter are based on Kolb’s (1976) theory. Therefore, Kolb’s definition of the learning process must first be taken into consideration and it states the following: learning is “the process whereby knowledge is created through the transformation of experience. Knowledge results from the combination of grasping and transforming experience”. This Experiential Learning Theory shows two ways of looking at experience: concrete experience and abstract conceptualization. This is based on the idea that an individual goes through a process of constructing knowledge, a learning cycle.

Kolb (2005) shows the behavior level has an influence on learning styles - Table 7.

Table 7: Behavior level in learning styles

<table>
<thead>
<tr>
<th>Behavior Level</th>
<th>Diverging</th>
<th>Assimilating</th>
<th>Converging</th>
<th>Accommodating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personality types</td>
<td>Introverted Feeling</td>
<td>Introverted Intuition</td>
<td>Extraverted Thinking</td>
<td>Extraverted Sensation</td>
</tr>
<tr>
<td>Educational Specialization</td>
<td>Arts, English History Psychology</td>
<td>Mathematics Physical Science</td>
<td>Engineering Medicine</td>
<td>Education Communication Nursing</td>
</tr>
<tr>
<td>Professional Career</td>
<td>Social Service Arts</td>
<td>Sciences Research Information</td>
<td>Engineering Medicine Technology</td>
<td>Sales Social Service Education</td>
</tr>
<tr>
<td>Current Jobs</td>
<td>Personal jobs</td>
<td>Information jobs</td>
<td>Technical jobs</td>
<td>Executive jobs</td>
</tr>
<tr>
<td>Adaptive Competencies</td>
<td>Valuing skills</td>
<td>Thinking skills</td>
<td>Decision skills</td>
<td>Action skills</td>
</tr>
</tbody>
</table>
The learning styles are sown in Figure 40 as follows:

- Diverging: concrete experience and reflective observation.
- Assimilated: abstract conceptualization and reflective observation.
- Converging: abstract conceptualization and active experimentation.
- Accommodators: concrete experience and active experimentation.

There are other theorists like Honey and Mumford (1986) who have developed parallel individual learning styles: activist, reflector, theorist and pragmatist.

Based on the Kolb (1984) model and coupled with behavior level, the researcher currently situates himself after the accommodator style, having completed the experience and being in reflective observation. The researcher has experienced every stage of this evolution, passing from assimilating, to converging, to accommodating and finally diverging. From the Honey and Mumford (1986) point of view, it is safe to situate the
researcher as a “Reflector” here because the researcher is reviewing what has happened. Indeed, at the beginning of work on this dissertation, the researcher was assimilating the services quality theories and models (the SERVQUAL model, the Five Gap model, Blueprinting, etc.) as well as all other available academic articles on healthcare services. Critically reviewing these articles enhanced the student’s skill in rigorously assessing the quality of an academic work. Furthermore, the application of service quality models learned in the Services Marketing module from the MA programme at the DBS made the student aware of the ways in which the quality of service must be assessed. Blueprinting was one of the tools used in looking at the design of the medical process which later served in the dissertation. These facts are proof of a positive learning curve occurring in the case of the researcher.

The researcher wanted to find out what were the quality factors that separated public healthcare services from the private healthcare services from the customer satisfaction stand point. And so he started conceptualizing after reviewing the academic literature and after defining the methodology and methods, he started active experimentation which led to the concrete experience. Being now in reflective observation, the researcher can say that he passed through every stage of the learning cycle.

6.2 Skill development

The aim of this section is to point out the skills that the researcher has developed over the past period while working on the dissertation.

6.2.1 Research and analysis skills

Firstly, it is safe to say that due to the education acquired at the Dublin Business School and the practical experience, the researcher has developed his research skills. The researcher has learned how to gather data from academic sources, looking at their reliability, schools of taught, year of issue, reproducibility and so on. While working with databases, the researcher has gathered valuable information about the referencing system and the importance of key words. Indeed, the researcher learnt how to reference consistent with the Harvard referencing style.
Secondly, the researcher is more confident in his analytical skills, being able to critically assess a research document or academic article more efficiently than before. This is on account of learning in an Anglo-Saxon culture, and acquiring through it more rigor and analysis skills. This is as also a result of critically reviewing the many academic articles in the literature needed for this dissertation. Indeed, currently, the effort put in looking at an article or reviewing a professional report is far less important as it was before. As the researcher is currently working in a medical services company (S.C MEDISPROF S.R.L) as an assistant manager, it is far easier to point out interesting facts in staff reports. Furthermore, there is a visible ease in criticizing medical specialty studies for their lack of generalisability, their weak theoretical basis and doubtful methodology of survey.

6.2.2 Marketing knowledge and skills

The researcher now possesses new marketing skills; more specifically services marketing skills, an area of personal interest. After seeing the findings of this dissertation, which show the existence of a significant “myopic” gap, the gap between management perceptions of consumer expectations and service expectations, the researcher finds himself right in the place where he can make a difference. Specifically, the researcher is now aware of how patients assess a medical service, what their expectations and perceptions are and as a marketer can intervene to close the gap between management perceptions and customer expectations.

Moreover, the researcher was made aware of the differences between a product marketing mix and a service marketing mix, which contains people, process and physical evidence. This theory served in developing skills in analyzing the healthcare services in Romania.

Furthermore, the researcher is now more confident of his skills to efficiently investigate and synthesize a marketing issue. In fact, due to primary research through face-to-face questionnaires, the researcher has learned to better communicate and understand the customer, being in constant proximity with the customer. This has also changed the researcher’s attitude towards the customer, going from an introvert approach to an extrovert one.
6.2.3 Communication and language skills

The researcher has learned through this experience to better communicate with both customers and with a team. The researcher has developed his communication skills in the sense that there is a new easiness to going forward and meeting the customer, listening to his opinions and having the patience and empathy in understanding his expectations and perceptions of a service. Furthermore, the researcher has developed communication skills in directing a team discussion such as a focus group, moderating a dialogue and taking valuable and essential notes of the main directions in the dialogue.

Language skills have developed in a sense that there has been a transition between the French environment and the Anglo-Saxon culture which focuses more on the rationale and has a more scientific approach. The language has changed from a more unstructured and free language to a more scientific one. Furthermore, by translating the English language into Romanian in order to create a questionnaire and focus group, the researcher has become aware not only of cultural differences (Romanians do not know what a focus group is) but also of the necessary language to employ in a study of a Romanian industry. Indeed, while westerners are used to a more complex language and to being asked to complete a survey, Romanians are not used to questionnaires therefore do not possess the understanding of complex words or phrases. The researcher often found himself in taking time to explain concepts and ideas such as “empathy” to some of the participants.

Consequently, the dissertation experience has made the researcher more aware of cultural differences, of the language differences and has accumulated communications skills.

6.2.4 Time management skills

Time management is a recurring problem for a researcher. While setting deadlines, planning and exercising control over the amount of time allocated for each task can be very useful tools, the final deadline can remain an impediment for the potential of a research. In the case of the current research, the impediment is the generalisability of findings and their representativity due to limited time. The researcher was obliged to prioritize tasks and limit the sample in order to attain a set timing. In order to do so, the researcher applied the Eisenhower method, said to have been used by U.S.
president Dwight D. Eisenhower. This method evaluates tasks as important/unimportant and urgent/not urgent. While this method was used to prioritize tasks, a Gantt chart was used to visualize the timeline of the project. In contrast with the Eisenhower method, the Gantt chart can also show dependency of tasks to other tasks.

In conclusion, the researcher developed time management skills through using different methods in prioritizing and setting deadlines for specific tasks during this research.

6.3 Further application of learning and skills

The elements that have been acquired while learning and what has been developed as skills through this experience will be applied in the job of the researcher. The researcher is applying them in his job as an assistant manager with the Medisprof Clinic, the company in which he conducted the focus group.

First, research and analysis skills will be applied in finding and analyzing medical research papers and internal reports. The experience acquired while completing this dissertation will allow the researcher to accelerate the reading and analyze the pertinence of medical articles and documents.

Second, language and communication skills will make team-work more facile. The researcher will now be able to use appropriate wording for internal documents and thus communicate better on the tasks that the team has to complete. Furthermore, the recording of the focus group provided the researcher with valuable feedback over his behavior as a moderator and this was an occasion to improve his communication skills.

Thirdly, time management skills will be useful in setting intermediate deadlines for tasks given and have a better distribution of time towards each action needed to fulfill a task.

Finally, this study of service quality in the healthcare systems from the patient satisfaction point of view could be just the first step in investigating more of the aspects that define this industry. The researcher could further concentrate on the importance of price in choosing a healthcare service, the segmentation of the population according to
their socio-demographic characteristics and their preference towards a healthcare service or finding out their needs in terms of health. Further studying healthcare service in Romania can be useful to private practices such as the company in which the researcher is currently working. Determining the needs of the patients, their socio-demographic characteristics, segmenting the population, learning more about consumer behavior in this matter could serve in defining the demand of the market and meeting this demand with adequate service.
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Other sources:
http://www.unicef.org/infobycountry/romania_statistics.html
http://www.insse.ro
http://www.cnas.ro/
Appendices:

A. Appendix: Questionnaire – first draft

General information:

1. What is your year of birth?
2. Gender: Male/Female
3. In which area do you live:
   a. Urban
   b. Rural

Use of healthcare services:

4. Do you have ease of access to medical care in general?
   a. Yes
   b. No
5. Do you or your relatives use both private and public healthcare services?
   a. Yes
   b. No
6. How frequently do you visit a hospital/healthcare facility?
   a. once a week
   b. once a month
   c. a few times a month
   d. every six months
   e. a few times a year
7. From your previous experience, when you or a relative need medical care, who decides which hospital or facility to chose?
   a. I usually decide
   b. I decide based on the information from my physician
   c. Me and my physician decide together
   d. My physician decides based on the information I give him.
e. My physician decides
f. It depends on the situation

8. Please number the quality factors below in order of importance when choosing a healthcare facility:
   a. Accessibility
   b. Price
   c. Professionalism
   d. Facilities
   e. Good image

9. Do you have greater expectations when choosing a private healthcare service than in the case of a public one?
   a. Yes
   b. No

10. When going to a hospital to undertake a surgical procedure, are you prepared to pay a bribe?
   a. Yes
   b. No
   c. Only in a public hospital

11. In order to know what your expectations are concerning healthcare services, please rate the items below with a score accordingly. If it is very important rate 1 and if it is unimportant rate 4:
   a. Access 4 3 2 1
   b. Empathy 4 3 2 1
   c. Tangibles 4 3 2 1
   d. Responsiveness 4 3 2 1
   e. Choice 4 3 2 1
   f. Information/communication 4 3 2 1
   g. Redress 4 3 2 1
   h. Representation 4 3 2 1
   i. Assurance 4 3 2 1
   j. Reliability 4 3 2 1
Healthcare services: Public vs. Private

12. You are in need of a specialist treatment, where do you go?
   a. Public hospital
   b. Private hospital

13. Is there a wide difference in performance between public hospitals and private hospitals?
   a. Yes
   b. No

14. Rate the following
   a. Public healthcare services
      i. Excellent
      ii. Good
      iii. Reasonable
      iv. Poor
      v. Awful
   b. Private healthcare services
      i. Excellent
      ii. Good
      iii. Reasonable
      iv. Poor
      v. Awful

15. Do you think that there are different standards of service quality between the public hospitals and the private hospitals?
   a. Yes
   b. No

16. In which case do you evaluate you have access to better equipment and conditions (ex: cleanliness)?
   a. Public hospitals
   b. Private hospitals
17. In your own experience, the staff has more professionalism:
   a. In a public hospital
   b. In a private hospital
18. In your opinion, in which situation the staff communicates with you to your understanding?
   a. In public hospitals
   b. In private hospitals
19. How would you evaluate the price of the following services:
   a. The price of a service in a public hospital
      i. Overpriced
      ii. Fair
      iii. Value for money
      iv. Cheap
   b. The price of a service in a private hospital?
      i. Overpriced
      ii. Fair
      iii. Value for money
      iv. Cheap
20. Which system do you consider to be more corrupt?
   a. The public system
   b. The private system
21. The following question concerns healthcare services image: Do you have a good image of:
   a. Public healthcare services?
      i. Yes
      ii. No
   b. Private healthcare services?
      i. Yes
      ii. No
   c. What influences you the most? (you can choose one or more answers)
      i. Advertising
ii. Word- of mouth
iii. Price
iv. Tangibles

22. For the following statement please tick the box that matches your view most closely: “The service in a private clinic is more expensive than in a public hospital”
   a. Strongly agree
   b. Tend to agree
   c. Not sure
   d. Tend to disagree
   e. Disagree

23. For the following statement please tick the box that matches your view most closely: “Private healthcare services are more accessible than public healthcare services”
   a. Strongly agree
   b. Tend to agree
   c. Not sure
   d. Tend to disagree
   e. Disagree

24. Are you satisfied with healthcare services? To what extent:
   a. Public healthcare services:
      i. To a large extent
      ii. To a quite large extent
      iii. To some extent
      iv. To a quite small extent
      v. To a small extent
      vi. Not at all
   b. Private healthcare services:
      i. To a large extent
      ii. To a quite large extent
      iii. To some extent
iv. To a quite small extent  
v. To a small extent  
vi. Not at all

25. What are the main quality factors that result in your satisfaction with a healthcare service?
   a. Reliability
   b. Tangibles
   c. Responsiveness
   d. Assurance
   e. Empathy
   f. Access
   g. Choice
   h. Information/communication
   i. Redress
   j. Representation
### Appendix: Revised questionnaire:

#### Informații generale

1. Vară:
   - [ ] 1. Masculin
   - [ ] 2. Feminin

#### Folosirea serviciilor de sănătate

4. Consideră ai avea acces cu un rată la serviciul medical?
   - [ ] Da
   - [ ] Nu

5. Dăstează ocazia unei vreo dezuvertorile de șanse ale serviciului public de sănătate la cel care privite?
   - [ ] Da
   - [ ] Nu

6. Mai decât o să fie oferită serviciile medicale?
   - [ ] Da
   - [ ] Nu

7. Cine decide în privința spitalului medicale dincluc?
   - [ ] 1. În domenii de decizie
   - [ ] 2. În cazul deciziilor pe care el îi face deciziile

#### Servicii medicale publice și servicii medicale private

11. Atei are serviciu de un tratament de specialitate, unde alegi să mergi?
   - [ ] La o clinică publică
   - [ ] La o clinică privată

13. Este o diferență semnificativă în serviciul de domenii în public și cel privat de sănătate?
   - [ ] Da
   - [ ] Nu

16. Este este calitatea serviciilor medicale cu o cifra de la 1 la 5, unde 1 = "Excepcional", 2 = "Doar bună calitate", 3 = "Rezumat", 4 = "Prințescă inebsă" și 5 = "integral rezumat"?
   - [ ] Da
   - [ ] Nu

17. Ai putea să-ți spui dacă este mai mare sau mai mică calitatea?
   - [ ] Da
   - [ ] Nu

18. În ce senzual personaj comună mai multe, pe atunci primul?
   - [ ] În primul se poate să fie accesibile
   - [ ] În al doilea se poate să fie accesibile

19. Este este calitatea serviciilor medicale cu o cifra de la 1 la 5, unde 1 = "Totul perfect", 2 = "Correct", 3 = "Bun raport calitate-preț" și 4 = "Teribil"?
   - [ ] Da
   - [ ] Nu

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C. Appendix: Informed consent - focus group

The participants will be asked to sign this informed consent which states the purpose of the meeting, the fact that the meeting will be recorded and confidentiality issues. This is needed for the case in which a participant has any reclamation.

"Consimtamant informat"

Ati fost de acord sa participati intr-o discutie de grup moderata de Serban Udrea. Scopul acestei intalniri este de a incerca sa intelegem care este perceptia pacientului asupra serviciului medical la stat si la privat, care sunt factorii de calitate care conteaza cel mai mult din punct de vedere al managementului si al personalului sanitar si auxiliar si care este situatia ideala in care pacientul este satisfacut complet de serviciile de care beneficiaza. Informatia din cadrul discutiei de grup va fi folosita pentru a interpreta golul dintre perceptia managementului si personalului din serviciile de sanatate asupra asteptarilor pacientului si serviciul asteptat de pacient.

Puteti alege sa nu participati la aceasta discutie si sa va opriti in orice moment. Desi discutia va fi inregistrata, raspunsurile dumneavoastra vor ramane anonime iar numele dumneavoastra nu vor fi mentionate in teza de master.
Nu există raspunsuri corecte sau incorecte la întrebări. Doresc să aud cât mai multe puncte de vedere și as dori să aud pe fiecare vorbind. Sper să fiti sinceri chiar și în cazul în care raspunsurile dumneavoastră nu sunt în acord cu restul grupului. Din respect unul pentru celalalt, va rog să vorbiti fiecare pe rand și raspunsurile participantilor să rămână confidentială.

Inteleg această informatie și sunt pe deplin de acord să particip la această discuție sub condițiile prevăzute mai sus:

Semnat:___________________________________________
Data:_______________

D. Appendix: Demographic data – focus group

The demographic data contains information about the age, sex, specialty and experience of the participants. This will be used to prove the validity of the focus group.

<table>
<thead>
<tr>
<th>Demografia participantilor la focus group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data:</td>
</tr>
<tr>
<td>Ora:</td>
</tr>
<tr>
<td>Locatia:</td>
</tr>
<tr>
<td>Care este specialitatea dumneavoastra?</td>
</tr>
<tr>
<td>o Oncologie</td>
</tr>
<tr>
<td>o Psihologie</td>
</tr>
<tr>
<td>o Medicina de familie</td>
</tr>
<tr>
<td>o Asistenta medicala</td>
</tr>
<tr>
<td>o Medicina muncii</td>
</tr>
<tr>
<td>De cat timp practicati meseria?</td>
</tr>
<tr>
<td>o Mai putin de 5 ani</td>
</tr>
<tr>
<td>o Intre 5 si 10 ani</td>
</tr>
<tr>
<td>o Mai mult de 10 ani</td>
</tr>
<tr>
<td>Care este media cazurilor/consulturilor noi pe luna?</td>
</tr>
<tr>
<td>o Mai putin de 5</td>
</tr>
<tr>
<td>o Intre 6 si 10</td>
</tr>
<tr>
<td>o Mai mult de 10</td>
</tr>
<tr>
<td>Unde ati practicat meseria?</td>
</tr>
<tr>
<td>o In sistemul sanitar public</td>
</tr>
<tr>
<td>o In sistemul sanitar privat</td>
</tr>
<tr>
<td>Varsta:</td>
</tr>
<tr>
<td>o Intre 20 si 30</td>
</tr>
<tr>
<td>o Intre 31 si 40</td>
</tr>
<tr>
<td>o Intre 41 si 50</td>
</tr>
<tr>
<td>o Intre 51 si 60</td>
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<tr>
<td>o Peste 60</td>
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<tr>
<td>Genul:</td>
</tr>
<tr>
<td>o Feminin</td>
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<tr>
<td>o Masculin</td>
</tr>
</tbody>
</table>
E. Appendix: The focus group script

The script of the focus group:

The focus group will take place in a meeting room with a projector. The moderator will arrive 20 minutes before the hour set for the focus group and prepare the environment (water, snacks, distributing the paperwork needed, start the projector).

At the arrival of the participants, the researcher will thank them for coming and present them with the informed consent and demographic data paperwork which they will have to sign and complete. Then, the moderator will proceed to start the presentation (3-4 slides) of his research and the justification for it and present the general rules and guidelines of the discussion. (10-15 minutes)

1st slide:

The first slide gives a brief definition of a focus group as there is no equivalent in Romanian.
2nd slide:

The second slide explains the purpose of the focus group, states the dissertation title and underlines the importance and relevance of the topic.

3rd slide:

The third slide sets the main rules of the focus group:

1. “I want you to talk, I want everyone to participate and I might interrupt the discussion and give the word to a person who hasn’t been talking.”

2. “There are no right answers, the experience and opinion of each is important.”

3. “Please don’t talk over one another.”
After the first three slides, the moderator will start with the focus group questions as follows:

Introductory question, to break the ice:

1. Where would you like to go for your next holiday?

Opening questions:

2. What is the first thing that comes to mind when thinking about patient expectations?

This is a general question and will be useful in getting the group thinking from a patient perspective and coming up with the basic ideas for patients expectations.

3. In your opinion, what does the patient evaluate (or what can he evaluate) in healthcare services?

This question is useful in determining what medical staff and management think about how the patient evaluates the medical service.

Key questions: The key questions are derived directly from the research questions previously stated.

4. In your opinion, what are the main factors that determine the patient to choose a health service?

5. Who decides where the patient will be treated/hospitalized/undertake surgery?
   a. Transition: Does he have to say anything in that decision?

6. What are, in your opinion, the main elements which separate public healthcare sector from the private sector?

7. Does the private healthcare sector offer better services?
   a. Transition: If yes, in what way are they better? What do they have to offer which is better?

8. Do you think that private healthcare services are perceived by the patients as being more expensive?
a. Transition: If yes, is that really the case when you take into consideration the monthly health contribution, the payment of the physician under the table and the purchase by the patient of needed medical supplies?

9. What do you think are the factors which determine patient satisfaction in a service?

Ending question: the ending question will ask the participants to summarize their views. This will help determine whether participants can argument and summarize and if they have been truly involved in the discussion and have gone in depth of the issue.

10. If you agree with the fact that private healthcare services offer better quality, please justify your answers and summarize your opinion. In the opposite case, please argument your answers and summarize your opinion.

Once the questions are addressed, the researcher will show the 4th slide:

The fourth slide shows the five gap model and here the moderator explains it to the understanding of the participants. This slide is presented at the end of the focus group meeting as a contribution of the researcher towards the participants.

The last slide will end the presentation in saying “Va multumesc pentru timpul acordat!” which means “Thank you for your time”.

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There will be a coffee break after 30 minutes of discussion if the participants wish for it.

F. Appendix: The Focus Group Flow

Q1. The opening question was a general question: “What is the first thing that comes to mind when you think of patient expectations?”

The answers to this question were diverse and can be summarized as follows:

The problem is with the patient, the doctors say. There is a great difference between patient expectations and what a physician can offer. More precisely, the patient expectations do not correspond with what a medical service is able to do for him. Furthermore, the patient’s idea of quality of service is not in accord with the doctor’s idea of service quality. The patients expect empathy, professionalism, communication and trust but ultimately, the greatest expectation of a patient is speed. Because he doesn’t understand the technical aspects of the job, he expects everything to be done quickly, to his convenience. This is unrealistic and puts more pressure on the physician.

Conclusion: there is an important gap between the expected service and physician perceptions of patient expectations. As it can be observed in the analysis of quantitative data, patients indeed expect professionalism and assurance but responsiveness is not the most important factor.

Q2. The second opening question was: “In your opinion, what is the patient able to evaluate in a medical service?”

The patient is able to evaluate promptness of service, empathy and tangibles. However, he cannot evaluate professionalism. The patient hopes for more promptness despite the fact that speed could result in negative care outcome. The patient also emphasizes on the cost of the service as a warranty of quality. If a service price is high, so must be the quality. This is because of disinformation.

Conclusion: Indeed, the patient is able to evaluate the tangibles of a service, the promptness and empathy but not professionalism in the medical field as a physician sees it. He cannot evaluate professionalism because that would require expert knowledge in
the medical field. However, a patient can evaluate professionalism from the outcome of a healthcare service, from the motivation a doctor has, from his behavior, etc. The answers to this question further accentuate the gap between doctor’s perception and patient expectations.

The following questions are **key questions**:

**Q3.** “What are the factors that determine patients in choosing a medical service?”

The patients prefer services that are accessible but also services that give them commodity, good ambiance, an agreeable reception, trust, tangibles and that aren’t corrupt. Furthermore, the reputation of the doctor in cause is very important as well as the variety of services a hospital or clinic has to offer. The patients are also sent to a doctor by another doctor, they do not always choose where to go.

**Conclusion:** The answers to this question are coherent with the similar question from the questionnaire in the sense that the patient appreciates tangibles when choosing a healthcare facility but the reputation of the doctor refers to the image and that was the least important factor in the choice.

**Q4.** “Who decides where the patient will be treated?”

The doctor decides where the patient will go for further treatment or investigations. There are only a few patient who decide for themselves and who afford to go abroad for better treatment.

**Conclusion:** the idea that patients are not usually given the choice and the doctor decides for them goes against the results from the questionnaire which show that in only 4% of the cases the doctor decides for them. This gap shows different perceptions concerning the decisions. The patients may be feeling that they are the decision makers while they follow the directions from the doctors.

**Q5.** “What are, in your opinion, the main elements that separate the public sector from the private one?”
There is a completely different approach in the public sector and in the private sector. In the public sector, a doctor or a patient does not have access without paying a bribe. In the case of a doctor looking for a position in public healthcare, he has the choice of either paying a bribe to get a job in the country or leaving the country. The corruption is augmented by the fact that there are a very limited number of positions. In the case of a patient, he has to pay a bribe in order to get a good treatment, food and so on. In the private healthcare services, the patient is put in the center and even if the personnel is the same as in public facilities, there is a self-imposed better behavior towards the patient. This is due to better organization, better payment for medical staff, the lack of corruption and a better management overall. There is more professional service offered in the private healthcare facility than in a public one due to these factors.

Conclusion: these answers complete the perspective concerning the differences between the public sector and the private sector. The questionnaire participants rated the quality of service in both cases, stating that the private sector had better quality service. They also defined the public system as being more corrupt, having different quality standards applied, being less professional and having less equipment. Physicians and management verify these opinions and add their insight concerning organizational policies, detail on the corruption problem and why the quality is better in one system and worse in the other.

Q6. “Does the private system offer better quality services?”

Yes, the private system offers better service quality but only in some cases. There are few specialties that offer good service in the public system, that haven’t developed as well in private clinics. This is due to financing that is difficult to get in order to develop specialties like radiology in private healthcare.

Conclusion: this answer concurs with patient perceptions of better quality in the private system and brings forward another detail which differentiates the two, the financing. Indeed, the private system is still in development and it takes time to get access to financing that would make it competitive in all medical specialties.
Q7. “Do you think that private healthcare services are perceived by the patients as being more expensive?”

Yes, the patients perceive private healthcare services as being more expensive even if it is not the case. In a private service, the patient is able to see and calculate immediately what he pays. In a public facility he pays a bribe to a physician, he pays a bribe to the nurse and so on, not even mentioning health taxes. This perception issue is also age related. Because a large number of people who need medical services are old, they perceive a greater cost of service than it actually is. This is due to their pension which is small. Furthermore, 80% of the patients do not perceive the differences between the public system and the private system and the cost of the services.

Conclusion: As the results of the questionnaire show, the perception of patients is that private services are more expensive than public ones. This is confirmed here in the focus group. The participants add another perspective, that of the unseen cost in the eye of the patient. Cost might not be different in the two cases after all. Another aspect that is said in the focus group is that perception could be age related. As seen in the results of the questionnaire, the average age of the respondents is 43 years old therefore perception of higher cost in the private facilities is not related to age.

Q8. “What do you think makes patients satisfied with a medical service?”

One important element is clearly the outcome of the treatment. Another may be the cost of the treatment. If the patient sees it as what he expected the service to cost, he might be satisfied. Another important factor is courtesy of the personnel, good communication concerning his diagnosis and treatment and making the patient feel the interest and commitment of the doctor in trying to help him. Accessibility is another factor that gives a patient satisfaction with the service.

Conclusion: this answer shows that there is a gap here also between what medical staff and management see would make patients satisfied with a service and the opinion of patients themselves. As stated in the previous section, the most important factors that
make patients satisfied with a service are: reliability and tangibles. Consequently, the only situation where the two reach a common point is courtesy which can be integrated in the tangibles factor.

**Q9.** “Please make a summary of your opinions”

*There is a great difference between public healthcare services and private healthcare services. In the first, the physician is in the center of the system while the latter has the patient in the center. While professionalism can be found in both systems, the private healthcare environment helps the doctor more in professional and personal development. Private healthcare has created a competitive environment and this is not only good for the patient but also for the doctors. In private companies there is a higher appreciation of individual values and a remuneration based on performance as opposed to the public system where the remuneration is independent of performance and the individual must do his job and not ask for more.*

**Conclusion:** the facts stated above represent a part of the reasons why public and private healthcare offer different quality of service and better explain the way the system works. Moreover, the summarized opinions here above clearly state the competitive advantage of the private industry, which is the focus on the patient through a good human resource management.