Evaluating the quality of health care by assessing patient satisfaction

Gabriela CIOLPAN*

Abstract

The performance of the healthcare system is obtained by evaluating the quality of the healthcare. The image obtained from health services assessments is important because it shows the degree to which they meet or exceed expectations. Attitudes towards health care are measured by the perception of patients through favorable or unfavorable responses to the care provided. The patient's satisfaction is obtained by evaluating his experience in healthcare, being concerned about the quality of the healthcare services. Between the quality of the medical services and the satisfaction of the patients there is a close connection, being a permanent challenge for evaluating the perception of the patients on the health services. Patient satisfaction represents their degree of satisfaction with their perception of a hospital quality management regarding the services provided by it and the results related to the health status, the interaction with the medical staff, having an impact on the evolution of their health status. Patients are increasingly responsible for managing their own health, and consumer information technologies are becoming a critical component of health systems. The methodological approach will be realized through a qualitative analysis through a prospective study, by reviewing the articles in the journals on identifying the particularities of the performance of a healthcare system. The performance of the health system can have a major influence on the national decision-makers to understand the characteristics and processes that contribute to the relative levels of performance.

Keywords: patient satisfaction, patient attitudes, performance, health service evaluation

Introduction

The quality of health services has been evaluated over time by defining methods of evaluating health services through the contribution of Avedis Donabedian, an important author in the quality system. According to Donabedian (1978), the evaluation of health services has to be carried out in different dimensions in order to be effective in improvement. Donabedian (1988) stated that quality assessment should be based on a conceptual and operationalized definition of "quality of healthcare". The dimension regarding "Participant empathy" (Sitzia and Wood, 1997; Duggirala *et al*., 2011) was to be further developed within the health systems.

* Gabriela CIOLPAN is PhD (s) at Alexandru Ioan Cuza University of Iasi, Romania, Doctoral School of Economics and Business Administration, Management Specialization, e-mail: gabriela.ciolpan@gmail.com.

In Romania, after 1990, with the appearance of new evaluation systems, the quality assurance of health services is improved, which monitors both the quality of the medical act, the organization of hospitals and medical clinics, as well as professional organizations in charge with the standards review (PSRO).

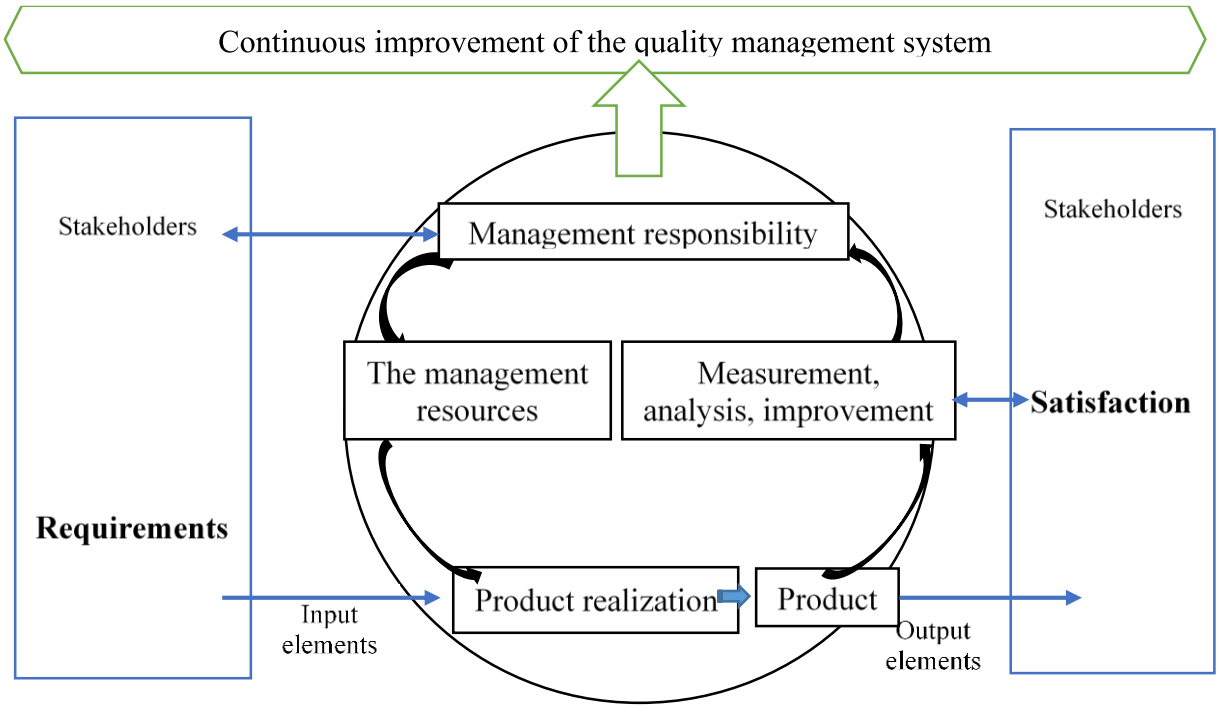
Starting with 1995, a concern begins with regard to the development of culture in quality management in the health sector. This strategy has led to a continuous improvement of the quality of health by implementing quality concepts in the health field, achieved by evaluating the health units on their level of compliance with the accreditation standards, performed by the National Authority for Quality Management in Health (A.N.M.C.S., 2018). Accreditation is the way in which a state or private medical unit demonstrates the way it provides medical care that meets the expectations of patients, both in terms of results and in terms of the conditions under which they are provided. The accreditation confirms that a medical unit has the resources and professional competences necessary to provide medical care in the specialties it has in the structure, leading to an increase in patients' satisfaction.

> In a study conducted in 2011 on 1124 patients from 17 hospitals, patients have a relatively high degree of satisfaction for the services provided, with a general satisfaction rate of 60% for 66% of hospitals; 55% for communication; 54% for doctors and medical staff; 54% for medical services. Thus, the quality of the services provided is related to: maintaining the cleaning, attitude, body language and tone of voice with which the staff addresses the patient; personalized attention etc. The assessment of patient's satisfaction in the context of hospital accreditation becomes a major concern for passing the test in order to obtain an accreditation certificate (Agheorghiesei and Copoeru, 2013).

We can say that, for a sanitary unit to function effectively, it must identify and conduct numerous inter-correlated processes. The application of a system of processes within a healthcare unit, together with the identification and interactions of these processes, as well as their management, can be considered a *process-based approach*. Used in a quality management system, such an approach improves the level of understanding and satisfaction of the requirements, obtaining results regarding the performance and effectiveness of the process, and continuous improvement of the processes based on objective measurements. The model of a quality management system based on process (SR EN ISO 9001:2008, 2008) presented in Figure 1 illustrates the links between the presented processes, highlighting the significant role that patients have in defining the requirements

as input data. The model shown in Figure 1 contains all the requirements of an International Standard, but does not present the processes at a detailed level.

Figure 1. Process-based quality management system model



Source: (SR EN ISO 9001:2008, Quality management systems. Requirements)

In the SR EN ISO 9001: 2001 standard, clause 0.2, it is mentioned that the PDCA methodology can be applied to all processes - Plan (P), Do (D), Check (C), Act (A), represents a method of organization and development of management activities, oriented in the direction of continuous improvement of the quality management system, designed and graphically represented by Dr. W. Edwards Deming and is also called the *Deming cycle*, the Shewhart cycle, or Deming's wheel. The known methodology PDCA can be applied to all processes and it can be described as follows: *Plan* – it sets the objectives and processes necessary to obtain the results in accordance with the client's requirements and with the organization's policies; *Performs* – it implements processes; *Verifies* - monitors and measures processes and the product against product policies, objectives and requirements and reports results; *Acts* – it takes actions to continuously improve the process performance.

1. Literature review

The concept of health system has become the center of the debate on health policy, which is applied by most ministries of health (World Health Organization, 2000), defined the health system as "all activities whose main purpose is to promote, restore or maintain the health". Thus, the mission of the Ministries of Health includes the promotion of health and the prevention of diseases, as well as the organization of health services. In the last decades, the decision-makers have contributed to the improvement of the health system, bringing changes in patient's satisfaction.

Pană *et al*. (2002) presents the modern management concept, oriented towards human capital, because people have as much role as financial or material resources in the production of goods or in the provision of health services. Human resources professionals are concerned with knowing the factors that influence the behavior and attitudes of employees to formulate and manage policies in accordance with the mission of the organization and the regulations in the field (Zlate, 2007). The development of human resources is the main form of adaptation to the new, continuing to invest in the training and development of medical capabilities (Pană *et al*., 2002). Donabedian, 2005, states that the efficiency of care is the final validator of the quality of care, obtaining or maintaining health and satisfaction, as defined for its individual members by a particular society or subculture.

Health policies are different in each country, influenced by a range of influences, including cultural, political and historical norms, but they share common goals of the health system and face similar challenges, such as demographic changes and rising costs. Most health systems aim to improve patient health, meet patient needs and, at the same time, ensure financial sustainability (World Health Organization, 2000). International comparisons offer a vast potential for learning both inside and abroad; providing a way to explore the different approaches that countries take to address similar issues to achieve comparable goals (Nolte *et al*., 2006).

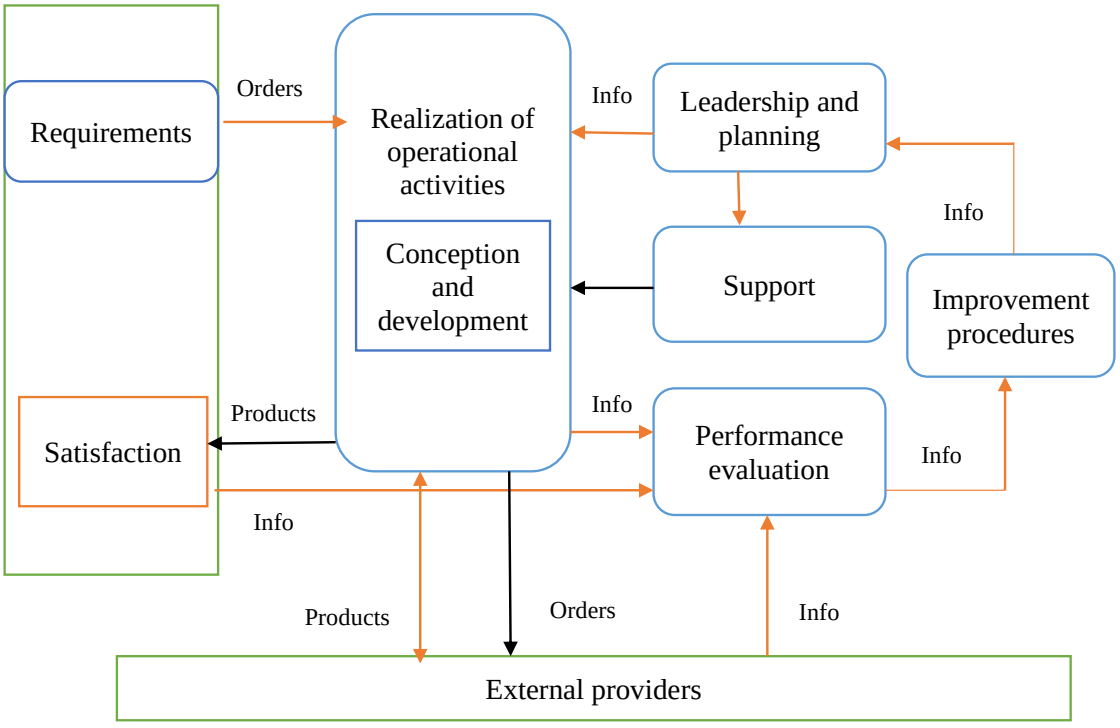
The performance of the health system can have a major influence on the national decision-makers to understand the characteristics and processes that contribute to the relative levels of performance. While the response to the 2000 World Health Report was an indication of the potential power of such comparisons, he also emphasized the limitations of comparisons of health systems, such as the lack of comparable data and underdeveloped comparison methodologies (Murray and Evans, 2003).

The patient's experience, reaction and satisfaction are correlated with the patient's expectations regarding the negative aspects of the health system. It concerns the availability of services, the choice

of the patient and how the system respects the dignity, autonomy and confidentiality of the patient, resulting in his satisfaction, experience and reaction (Busse, 2013).

Patient satisfaction is the essential objective for the hospital units. They follow the patients' current and future needs and try to fulfil their expectations, using all the necessary resources (material and human), which vary according to the degree of culture, the level of education and the individual perception on the individual's health or illness, on the structure, services and medical staff with whom the individual gets in touch. The statistical analysis of the results obtained regarding the perception of the medical team on the performances of the care and the medical assistance offered is an important component of the quality of the medical act and has an impact on the patient's safety and implicitly on the quality of the care and the medical assistance (A.N.M.C.S., 2018). The most important role in the development, implementation, maintenance, improvement and verification of the processes of the quality system, to raise the staff's awareness on the requirements of the patients, to develop the spirit of quality, to animate the quality system of the hospital and to report its operation belongs to the quality management responsible. He/she is the engine that develops the involvement of the entire hospital staff, addressing measures to achieve the objectives proposed in the quality management plan in the hospital.

Figure 2. Simplified interaction scheme between processes



Source: Gruez, 2015 - MAQ.100.001 Manuel qualité ISO 9001

Figure 2 represents a logical diagram of the interactions between the processes within the hospital, monitored by the quality management in order to maintain patient satisfaction. The relevant data for measuring the performance of the health system are collected through surveys on patients or the general population, and the satisfaction scores represent attitudes towards the aspects of care, while the general population comes with specifications of satisfaction with the health system. Satisfaction measures vary considerably in two particular aspects: the group whose satisfaction is measured and the type of satisfaction (Papanicolas and Cylus, 2015).

This aspect is influenced in the last years by the socio-demographic characteristics and the characteristics of the health services provision, having an impact on the reported satisfaction and can create prejudices. However, the power and direction of the relationship between satisfaction and socio-economic categories are not consistent (Bleich *et al*., 2009). Similarly, studies have found that patient satisfaction cannot be closely correlated with health outcomes or the technical quality of the care provided. Rather, patients were influenced by the manner and means of healthcare processes, such as the choice of provider or a good patient-physician relationship (Crow *et al*., 2006). Problems related to survey design, such as scaling and formulation, are also likely to create variations in responses.

In an analysis on international satisfaction data, Busse (2013) identifies three factors that can influence survey responses: (1) the context in which a survey takes place, (2) the ability of respondents to differentiate between the system as a whole and some subsectors of which the respondent may have special knowledge and (3) the inability to differentiate between the health system and the government in general. These factors can be applied both to individuals and countries, and the lack of universally accepted terminology can further complicate the development of comparable values.

In addition, expectations regarding the health system performance, on which individual satisfaction levels are inherently based, may vary depending on patients and populations. Respondents with lower expectations may report greater satisfaction regarding unsatisfactory care and vice versa. This bias has determined many researchers to explore respondents' experiences regarding the care, in addition to more subjective attitudinal questions (Jenkinson *et al*., 2002). An increasing number of such international indicators is now available for a subset of countries (such as those covered by the Commonwealth and OECD Funds).

EU intervention in health systems has been amplified, out of the concern on this public health to provide European citizens with good health, which is a key element not only in the happiness and

well-being of the individual, but also in the broader social context of social cohesion, productivity and economic development.

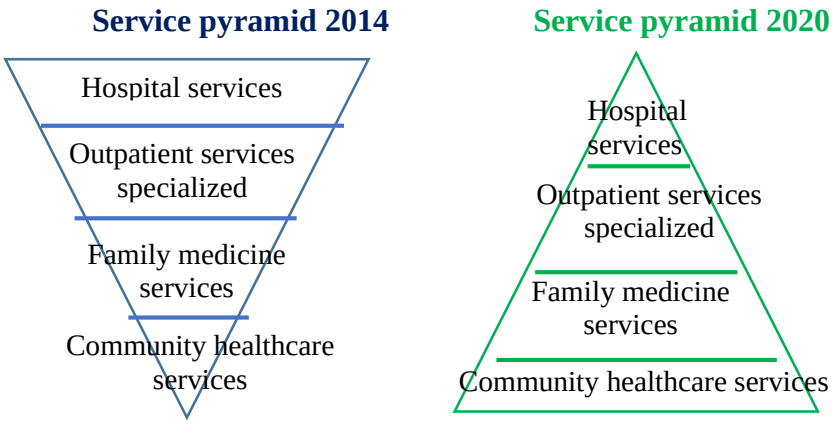
2. Health policies at European level

By analysing the European health systems, it can be said that health is considered a social right at European level, to which all citizens have access. At all levels of European health systems there are directions for their reform, due to the increased tax pressures over the years. Therefore, we focus on new financial sources, on how to manage them as efficiently as possible and on alternative ways of organizing services.

The role of the European Commission is to support the efforts of EU Member States to protect and improve the health of their citizens and to ensure the accessibility, efficiency and flexibility of their health systems. The EU strategy called Together for Health (2007-2013) supports the current Europe 2020 Strategy (2014-2020).

The National Health Strategy 2014-2020 (Figure 3) aims to reverse the current services pyramid by gradually developing primary care services, namely community health care, family medicine and specialty clinics (The Government of Romania, 2014). It also aims to obtain continuity of assistance and the integration of providers in defined geographical areas (regions, counties). In support of these objectives, the regional plans of health services (Ministry of Health, 2016) were approved in 2016 for the development of the regional services networks with the correct and efficient distribution of the providers in the primary, secondary, tertiary and long-term sector. Regional health service plans aim to change the current configuration of providers and services, based on the specific needs of populations in the eight development regions, demographic and epidemiological developments and technological advances. This will lead to the shift from focused services to hospital care to patient-centered care.

Figure 3. Consumption of health services



Source: Ministry of Health, The National Health Strategy 2014-2020 provides a vision on the provision of healthcare services

The main medium-term planning tool for the health sector in Romania is the National Health Strategy (Ministry of Health, 2014), which focuses on: public health, health services and measures at the whole system level, which sets the main objectives for each of them. The objectives of public health are to improve the health and nutrition of mothers and children; reducing mortality and morbidity caused by communicable diseases and slowing the growth rate of impermissible diseases. The supervision of the quality of healthcare is strongly supported by the use of relevant quantitative indicators that complete other approaches that may include qualitative analyses of specific events or processes. For the healthy population, indicators can also be important in terms of prevention, quality of life and health care satisfaction (European Commission, 2017).

3. Models of medical health services

Globally, there are 196 countries that have some form of healthcare. From well-regulated health care systems to shaman-dependent local villages, there are various approaches to providing and treating healthcare. In Europe, three models of public health systems were affirmed, with the main arguments being the financing method and the organization of the offer.

Bismarck health systems are financed on the principle of social insurance, by contributing a share of income by employers and employees in the labour field, by non-profit institutions. Their activity is carefully monitored at the public level, being frequently subjected to criticism from medical staff or service beneficiaries (that certain policies are not transparently applied, that the most equitable redistribution of resources is not carried out, etc.). The Bismarck model uses resources from the public budget or other categories of grants to finance public health programs. Currently, due to the

difficulties of collecting resources, on the background of increasing unemployment and narrowing the social financing base; the model is experienced by Germany, Austria, the Netherlands, France, Belgium (Stanciu, 2013).

Beveridge health systems where funding and supply are managed in an organizational system, namely funding bodies and providers are wholly or partially in an organization, such as the NHS in the UK, the Northern States, etc. The UK system is among the low-cost systems in the EU, where access to health services is increased, with increased equity, but is accompanied by limited options and freedom of choice. Beyond legal rights, there are also difficulties in accessing health services in Western European countries, but they are greater in former communist countries, as the data show (European Commission). In a global overview on European systems, we can say that accessibility to health services is satisfactory in both Western and Eastern Europe (European Commission, 2018). The problems regarding the quality of services and the financial sustainability of the eastern systems are more acute than the difficulties of covering the services of the population. The measure of access to services is an element of social justice and solidarity and a measure of the citizen's right to pay the provider's taxes (in the case of Romania, the health insurance contribution); however, the extent to which the services offered are of high quality and not only if they reach the beneficiary, is important. From this point of view, the East-West gap is larger than in terms of service coverage, the same report points out (Alber and Köhler, 2004). The most frequent critics addressed to this model refer to the limits of the basic services package, to the limits of the resources allocated to the treatment of certain conditions, to the consequences of the too long intervals on the waiting lists, for the population that cannot afford to contract private insurance. Such a model is experienced by the UK, Finland, Norway and Sweden.

The centralized state system - the Semasko model, has been applied for decades in the countries of Central and Eastern Europe, former socialist states, including Romania, with different results from one country to another, and from one era to another. This model is close, as a generic principle to the Beveridge model, meaning that the financing, organization and management is performed by the state, and in the Bismarck model by collecting resources in the form of participation rates for financing, applied to a disciplined salary mass and, usually, extended. The Semashko model differs from the Beveridge model by requiring patients to use only the services provided in their area of residence, and the Bismarck model by operating in an economic environment where private health insurance is lacking. However disastrous the system was before 1989, the Romanians often regretted it, especially after 1997, when the reform in the Romanian medical sector became widespread.

The European countries have not adopted, in pure form, one of the models described above, choosing to cross their characteristics, opting for a coordinate of the system for which they have

granted more importance and more resources, depending on the targeted social strategy and political ideology. Thus, each regulated either universal access to a basic service package, the rest of the services being provided according to the resource limits and the order placed on the waiting list, or they regulated a greater freedom of the consumers' choices on services, but increasing the costs of insurance (contributions or taxes) and services. Currently, the British system is one of the most effective and least expensive social systems in the EU, even though over one million patients are on waiting lists for different interventions (Vlădescu *et al*., 2000). Statements like - model x is preferable to model y - are debatable. Social practice has shown that no medical system can be more efficient than its management apparatus and the state that regulates and finances it. The distrust of some state institutions is felt in the efficiency of collecting and attracting the resources necessary for the medical services, in adopting fair and appropriate medical policies for the social situation of the population, in the proper organization of the public offer in the territorial profile or in putting the resources to work in the system. Thus, the most eloquent criterion of classification of health systems is the efficiency with which the system mobilizes and uses resources for medical purposes.

The financing of the medical assistance in Romania is mainly provided by the National Health Insurance Fund (The Romanian Parliament, 2015), supplemented by amounts from the state budget, the own revenues of the Ministry of Health, as well as the own incomes of the population. The budget of the National Health Insurance Fund is annually approved by the Romanian Parliament as an annex to the Law on the State Budget (National House of Health Insurance, 2018).

The private or voluntary health insurance system (American model) is that system in which the financing is based on the insurance premiums determined by the health status and the risks of the insured persons. The US model underlines the freedom of choice with state-funded health investments (14 % of GDP for health), but has 35 million citizens who are uninsured and do not have access to medical services. The main disadvantages of this model are the low accessibility of the population to healthcare and the high costs that it increases.

For over a half of century, since the British formation of the National Health Service (NHS), it has established universal access to health care, being a public health service funded mainly by tax. With more than a million employees, it is the largest non-military employer in Europe, being the largest Beveridge system in Europe.

4. Evolution of health systems

In order to become a strong player, the health care consumer needs access to information so that he/she is able to compare health policies, consumer services and quality outcomes. The Euro Index for Health Consumers (EHCI) is represented by efforts to provide health care consumers with such tools (OECD/ EU, State of Health in the EU, 2017). Thus, the consumers of medical services gain from the transparency of the comparative evaluation, and the quality and function of the health care systems improve as the results are displayed and analysed in an open, systematic and repeated way. This agreement seems to be shared by the European Commission, in 2016, the initiation of the formation of an evaluation system aimed at identifying successful national health systems. It is said that the ultimate goal is to consolidate best practices in the EU to provide better medical services. The aim is to select a limited number of indicators, in a certain number of evaluation areas, which in combination can present the way in which the consumer of medical services is served by the respective systems.

The countries included in the EHCI 2005 were: Belgium, Estonia, France, Germany, Hungary, Italy, the Netherlands, Poland, Spain, Sweden and the United Kingdom and, for comparison, Switzerland. The number of indicators was also increased, from 20 in the EHCI 2005 to 28 in the number from 2006. The number of sub-disciplines was maintained at five; with the modification according to which the sub-discipline "Friendship with the client" was merged in "Rights and information of the patient". To test this, the new "Generosity" sub-discipline of public health care systems was introduced in 2009, called "Range and coverage of services". One problem with this sub-discipline is that it is too easy to land in a situation where an indicator becomes just another way of measuring national wealth (GDP/ inhabitant). The index in 2018 is maintained by building with indicators grouped into six sub-disciplines (this number has varied). In the EHCI 2013, the sixth sub-discipline, *prevention*, was introduced (Table 1). Thus, the expert group established a total of 46 indicators in the EHCI 2018. Therefore, the percentages of the complete scores were added and multiplied by (1000/ total weight), the maximum theoretical score obtained for a national healthcare system in the Index is of 1000, and the lowest possible score is 333.

Table 1. The points in each sub-discipline are summarized

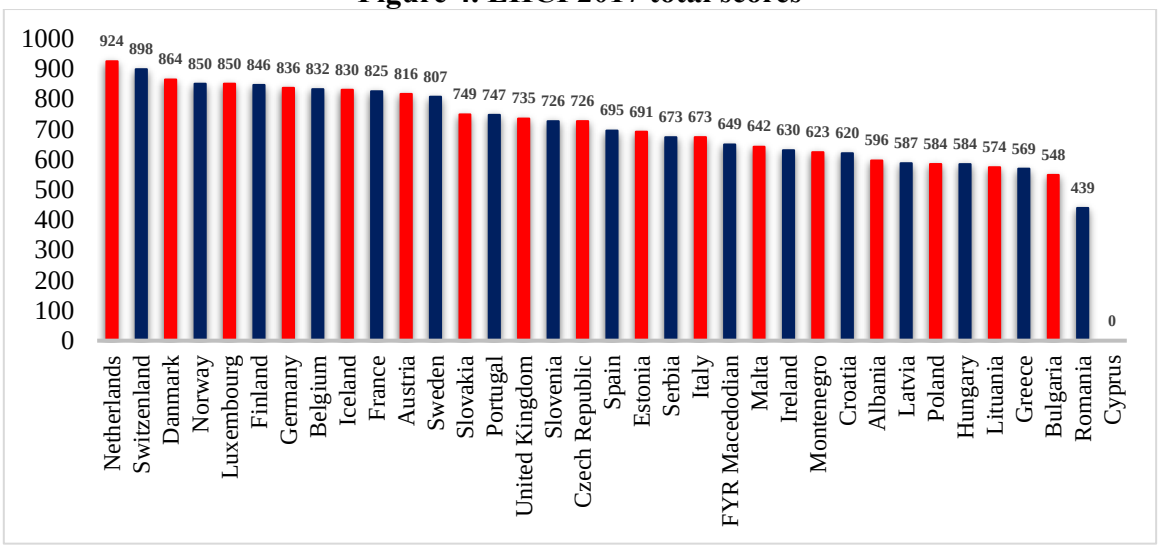
Sub-discipline	Top country/ countries	Score	Maximum score
1. Patient rights and information	Netherlands, Norway	125	125
2. Accessibility	Switzerland	225	225
3. Outcomes	Finland, Norway, Switzerland	278	300
4. Range and reach of services	Netherlands, Sweden	125	125
5. Prevention	Norway	119	125
6. Pharmaceuticals	Germany, Netherlands	89	100

Source: Euro Health Consumer Index, Report, 2018

The health system in the first position of the ranking is largely with uniform performance in the sub-discipline, excellent medical quality and excellent accessibility. Switzerland is at the forefront of accessibility with Belgium, Serbia and Bulgaria. The Swedish assistance system as a real competition obtained a high score in the range of services and met with the Netherlands, which, by Swiss standards, represents performance.

A comparative index for national health systems Figure 4 confirmed that there is a group of EU member states that have well-rated patient care systems. The Netherlands remains in the leading position in 2017, considered "the best healthcare system in Europe". The second place is Switzerland, maintaining the reputation of having an excellent health system, and the third place in the ranking is Denmark, which until 2016 occupies the 9th position in the EHCI ranking. Denmark has achieved high results in terms of hospital treatment outcomes, and Danish patients have learned to cope with very strict rules for access to medical services. Norway (also a winner or joint winner of three sub-disciplines) ranks the 4th with 850 points, sharing this position with Luxembourg.

Figure 4. EHCI 2017 total scores



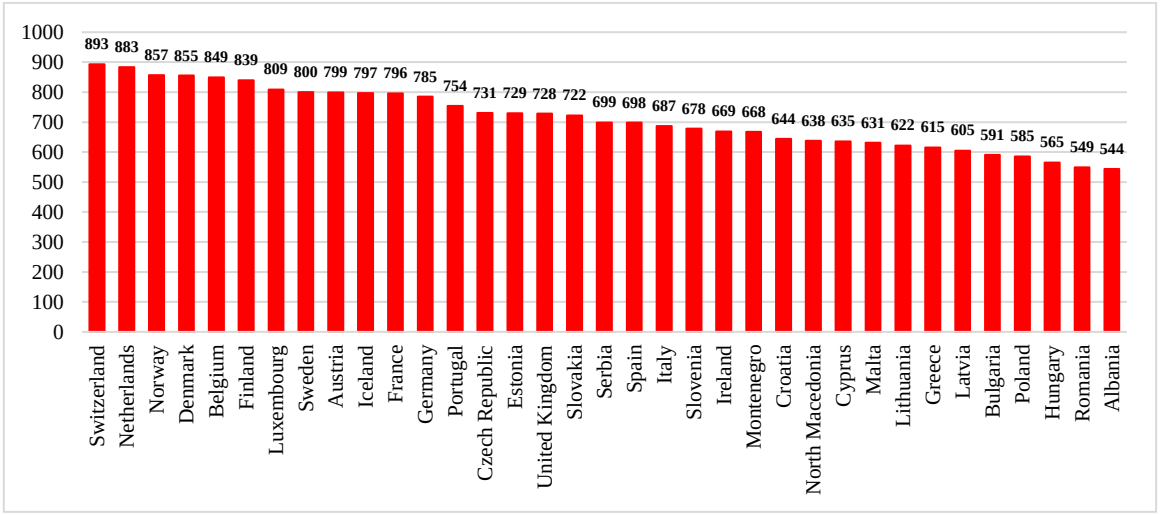
Source: Euro Health Consumer Index, Report, 2017

Some Eastern European countries are surprisingly well-rated, especially Slovakia, Slovenia, the Czech Republic and Estonia, given the much lower per capita health care costs. Romania has the lowest score in this category. In Romania, the system has a strong social orientation, with a low collection base, because the contributors to the system are few in relation to the beneficiaries of the system. In southern Europe, Spain and Italy provide healthcare where excellence can be found.

In general, European healthcare continues to improve, but statistics on health outcomes are still very low in many countries. For example, in terms of mortality risk status number one is represented by cardiovascular diseases, and the fatality of day cases for patients with hospitalized heart attack has to be compiled from several disparate sources. Therefore, this indicator (3.1) has been modified. By analysing the results of Figure 5 - Euro Health Consumer Index 2018 Total scores, it is very difficult to avoid seeing that the upper part of Bismarck countries has small populations, which leads to easier management. Large Beveridge systems seem to have difficulty achieving excellent customer value levels. The largest Beveridge countries are: the United Kingdom, Spain and Italy, are held together in the middle of the Index. The scoring criteria were strengthened on some indicators in EHCI 2018, to maintain the challenging index. However, there are 8 countries in Western Europe that have gathered over 800 points from the theoretical maximum of 1000 ("All Green" on each indicator). EHCI in 2018 rewards real clinical excellence more than in previous years.

The total EHCI 2018 ranking of health care systems, for the first time in the last ten years, does not belong to the Netherlands (Figure 4), which loses 41 points by introducing the two new mental health indicators (now 883 points), Switzerland taking the top position in 2018, which lost only 5 points in tightening the scoring criteria, obtaining 893 points out of 1000.

Figure 5. EHCI 2018 total scores



Source: Euro Health Consumer Index, Report, 2018

In Romania, regarding the analysis performed by the National House of Health Insurance (2018), it is observed that there are minimal variations in the assured perception of the quality of the medical services provided, generally presenting a tendency of satisfaction first of all with regard to the attitude of the medical staff. The patient is more impressed by the degree of empathy with which he/she is offered than by the medical professional expertise.

Public health spending for EU GDP was 7.8 % in 2015. The ratio of health spending to GDP is at least equal to the EU-weighted average in eight Member States: Belgium, Denmark, Germany, France, the Netherlands, Austria, Sweden and the United Kingdom. The Member States with the lowest share of public health cost were Cyprus and Latvia (3.5 %), and the countries with less than 5 % were Bulgaria, Estonia, Lithuania, Hungary, Poland and Romania. The Czech Republic, Germany, Croatia, Ireland, Lithuania, the Netherlands, Austria, Slovakia and the United Kingdom exceeded the EU average (15 % of the total of EU public spending in 2015). The lowest Member States were Cyprus (7.2 %) and Romania (8.4 %), followed by Greece, Latvia, Hungary, Poland (below 11 %) and Luxembourg (11.5 %). A prominent feature in the post-crisis period of 2014, is a visible stratification between the rich and the least rich countries, which is no longer found in 2016. However, the performance of some countries as it shows that the GDP/ inhabitant does not have to be a dominant factor, although it is an upward trend, which we can say that European healthcare is improving over time.

Conclusions

EU intervention in health systems was amplified to provide European citizens or good health, which is a key element not only in the happiness and good individual condition, but also in the wider social context of the social cohesion, productivity and economic development. Public health services continue to be effective, being evaluated by the patient's position on the therapeutic pathway, with a special focus on his/her satisfaction by improving the access to good quality care through the reduction of the waiting time, fiscal policies and social protection relevant to vulnerable categories, provision of quality care according to patients' expectations, promotion and assessing their quality and effectiveness, promotion of healthy aging and prevention of physical degradation of people with chronic conditions. Thus, it will increase the access to quality health services, through care focused on the needs of each patient.

References

A.N.M.C.S. (2018, july), National strategy for quality assurance in the health system, for the period 2018-2025, Quality in health (Retrieved from https://anmcs.gov.ro/web/wp-content/uploads/2018/11/strategia-calitate-in-sanatate.docx).

Agheorghiesei, D. T., and Copoeru, I. (2013), Evaluating Patient Satisfaction A Matter of Ethics in the Context of the accreditation Process of the Romanian Hospitals, *Procedia - Social and Behavioral Sciences*, 82, doi:10.1016/j.sbspro.2013.06.283

Alber, J., and Köhler, U. (2004), *Health and care in an enlarged Europe. Quality of life in Europe*, Office for Official Publications of the European Communities (retrieved from www.eurofound.eu.int).

Bleich, S., Ozaltin, E., and Murray, C. (2009), How Does Satisfaction with the Health-care System Relate to Patient Experience? *Bulletin of the World Health Organization,* 87, 271–280.

Busse, R. (2013), Understanding Satisfaction, Responsiveness and Experience with the Health System, in: Papanicolas, I. and Smith, P. C. (eds.), *Health System Performance Comparation*, Maidenhead: *Open University Press*, 255-280.

Crow, R., Gage, H., Hampson, S., Hart, J., Kimber, A., Storey, L., and Thomas, H. (2006), The Measurement of Satisfaction with Healthcare: Implications for Practice from a Systematic Review of the Literature, *Health Technology Assessment,* 32 (6), 1–244.

Donabedian, A. (1988), The quality of care: How can it be assessed? *Journal of the American Medical Association*, 12 (260), 1743-1748. doi: 10.1001 / jama.1988.03410120089033

Donabedian, A. (2005), Evaluating the Quality of Medical Care, Published by Blackwell Publishing. Milbank Memorial Fund, 83 (4), 691 - 729.

Duggirala, M., Polavarapu, R., Kambhatla, N., and Garg, D. (2011), An integrated service quality framework for global delivery of Contact Center services, SRII Annual Global Conference, doi:10.1109/SRII.2011.100

Elberse, J., Pittens, C., Buning, T., and Broerse, J. (2012), Involving the patient in a scientific consultative process: establishing the research agenda for medical products, *Health policy*, 107 (2 - 3), 231 - 242.

Euro Health Consumer Index. (2005), Report 2005. *Health Consumer Powerhouse - National healthcare agencies*.

Euro Health Consumer Index. (2013), Report 2013. *Health Consumer Powerhouse - National healthcare agencies*.

Euro Health Consumer Index. (2017), Report 2017. *Health Consumer Powerhouse - National healthcare agencies*.

Euro Health Consumer Index. (2018), Report. *Health Consumer Powerhouse - National healthcare agencies*, 28.

European Commission. (2017), State of Health in the UE, Romania: Country Health Profile 2017, *OECD Publishing, Paris/European Observatory on Health Systems and Policies*, 20. doi.org/10.1787/9789264285392-ro

European Commission. (2018), Health at a Glance: Europe 2018: State of Health in the EU Cycle. Raport. *OECD Publishing, Paris/European Observatory on Health Systems and Policies*. doi.org/10.1787/23056088

Eurostat. (2013), *Public health expenditure as a percentage of total government expenditure and GDP*, UN Statistical Division - Commission Services calculations.

Eurostat. (2015), *Public health expenditure as a percentage of total government expenditure and GDP*, UN Statistical Division.

Gruez, J.-F. (2015), MAQ.100.001 Manuel qualité ISO 9001. 10.

Jenkinson, C., Coulter, A., and Bruster, S. (2002), The Picker Patient Experience Questionnaire: Development and Validation Using Data from In-patient Surveys in Five Countries, *International Journal for Quality in Health Care*, 14, 353–8.

Ministry of Health. (2014), *National Health Strategy 2014-2020* (Retrieved from http://www.ms.ro/strategia-nationala-de-sanatate-2014-2020/).

Ministry of Health. (2014), Order no. 987 - regarding the approval of the implementation report of the National Health Strategy. National Health Strategy 2014-2020. Implementation Report Order no. 987 (Retrieved from http://www.ms.ro/strategia-nationala-de-sanatate-2014-2020/).

Ministry of Health. (2014), The National Health Strategy 2014-2020 provides a vision on the provision of healthcare services, Anexa 1, 24 (Retrieved from http://www.ms.ro/wp-content/uploads/2016/10/ Anexa-1-Strategia-Nationala-de-Sanatate-2014-2020.pdf).

Ministry of Health. (2016, December 8), Order of M.S. No. 1376/ 2016 - Approval of Regional Health Service Plans. *The Official Monitor nr. 988/ 08 decembrie 2016* (Retrieved from http://www.legex.ro/Ordin-1376-2016-150515.aspx).

Murray, C., and Evans, D. (2003), *Health Systems Performance Assessment: Goals, Framework and Overview*, World Health Organization, 3 – 23 (Retrieved from https://www.who.int/healthinfo/paper06.pdf).

National House of Health Insurance (2018), *Assessing the satisfaction of policyholders against the quality of health care provided in the health insurance system* (Retrieved from https://sgg.gov.ro/new/wp-content/uploads/2019/10/RAPORT-1.pdf).

Nolte, E., Wait, S., and McKee, M. (2006), *Investing in Health: Benchmarking Health Systems*, Nuffield Trust (Retrieved from https://www.nuffieldtrust.org.uk/resource/investing-in-health-benchmarking-health-systems/).

Pană, B., Duţă, I., Chiriac, N. D., and Moga, C. (2002), *Communication and social marketing guide: tools to promote communication in health,* Bucureşti: Universitară „Carol Davila".

Pană, B., Duţă, I., Chiriac, N., Moga, C., Stoicescu, G., and Vasile, D. (2003), *Communication and social marketing guide: tools to promote health communication*, 194 (Retrieved from http://www.worldcat.org/oclc/895105269).

Papanicolas, I. and Cylus, J. (2015), *Comparison of healthcare systems performance,* in: Kuhlmann, E., Blank, R. H., Bourgeault, I. L. and Wendt, C. (eds.), The *Palgrave International Handbook of Healthcare Policy and Governance*, Basingstoke, UK: Palgrave Macmillan, pp. 116-134.

Powerhouse, H. C. (2017), *Euro Health Consumer Index*.

Sitzia , J., and Wood, N. (1997), Patient satisfaction: a review of problems and concepts, *Social science and medicine,* 45 (12), 1829-4183.

SR EN ISO 9001: 2001 (2001), *Quality management systems* (Retrieved from https://www.srac.ro/ro/calitate-iso-9001).

SR EN ISO 9001:2008 (2008), *Quality management systems. Requirements*, *ASRO* (Retrieved from https://www.tuv-austria.ro/certificari/certificare-iso-9001-sisteme-managementul-calitatii/).

Stanciu, M. (2013), The public system of medical services in Romania in a European context, Quality of life, *Social Politics,* 24 (1), 47 - 80.

The European Commission. (n.d.), Eurobaromtru (Retrieved from http://ec.europa.eu/).

The Government of Romania. (2014, December 8), Government Decision No. 1028/ 2014 - The National Health Strategy 2014-2020 and the Action Plan. *The Official Monitor NR. 891, 8 december 2014*(891 bis) (Retrieved from http://legislatie.just.ro/Public/DetaliiDocument /163641)

The Romanian Parliament. (2015), Law nr. 95/ 2006 - Health Reform, republished, as subsequently amended and supplemented. *The Official Monitor of Romania, Part I, nr. 652* (Retrieved from http://legislatie.just.ro/Public/DetaliiDocument/71139).

Vlădescu, C., Butu, C., Dragomirișteanu, A., Fărcășanu, D., and Zamfir, E. (2000), *Management of health services*, Bucharest: Expert.

World Health Organization (2000), *World Health Report 2000. Health Systems: Improving Performance* (Retrieved from https://www.who.int/whr/2000/en/whr00_en.pdf?ua=1).

Zlate, M. (2007), *Treatise of organizational-managerial psychology*, Polirom.