MANAGEMENT DIRECTIONS IN THE PRIVATE HEALTH SYSTEM

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Abstract*: The article refers to the development of private health services and to the correlated management aspects. Comparative analyses of state and private health systems are presented. Also, the main principles of the private health system management and management directions in the relation with the patient and personnel are discussed. The management in the system of private health services has a series of particular characteristics: adoption of corporate management practices, organizational culture focused on performance and client, focus on the business and professionalism development.*
Keywords: *management, health services, private health system.*

1. Introduction

One of the European tendencies for management improvement of health services aims the reduction of discrepancies concerning the administration of services, access of population, quality and medical performance. More directions of actions have been launched:

- improvement of financing,
- efficiency increase of public providers,

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- reduction of extensively covered services,
- share increase for less covered services (e.g. home assistance),
- regulation of service payment (co-payment or payment in the private health system),
- development of systems of private health services.

The update of health systems at a reasonable quality level existing worldwide can be carried out more rapidly and efficiently by *stimulating privatization* or *founding private health units*. Also, the *stimulation of health insurance in the private system* is desired, mechanism which brings additional funds and increases the transparency and efficacy of system administration.

The most efficient and elegant solution to compensate some of the problems of the national health system was the occurrence of the private alternative of services. Medical practices, clinics and then hospitals appeared. A real *private health system* developed. This system evolved with great efforts, extended, managing to attract valuable human capital and confidence of the population. In the present, this became a viable system, which provides best quality services, at European level.

We can say that in Romania we have a state and a private health system. From administrative point of view, the activities of private units are regulated by laws and standards; it is a "system" with a high degree of administrative independence. The two systems are not in contradiction relations, but complementarity relations. It can be said that there is also a "competition" relation.

The arguments in favour of the development of the private health system were:

- *freedom of choice*: the system of private health services is an alternative for overcoming the crisis moments, a condition for increasing the quality of services and satisfaction of beneficiaries.
- *quality*: complete services are provided, modern diagnosis, very comfortable accommodation conditions, highest level treatment.
- *balance of demand with the offer*: the private health system is an important lever which improves the situation from the public health system.
- *assumption of risks*: the absorption of a part of the clients and the payment of insurance lead to the reduction of risks of medical state units (damage of buildings, equipment theft, risk of contamination,

patient injury) – the private health system absorbs and assumes a part of the inherent risks in the health services.

- *efficiency*: it is a non-inflationary financial source, it allows the avoidance of high and uncontrollable cost of services, it introduces money, deductibility in the budget, it compensates the deficit from the national health insurance fund which does not cover the *population requirements*, it prevents corruption.
- *efficacy*: it provides more facilities in ambulatory and hospital activity, it can solve more of the problems of employees (Ciurea et al., 2009).

The private health units were founded with great. Such a viable unit needs major logistic effort, planning of structures and activities, actions of feasibility analysis, recruitment and selection operations of highly qualified personnel, connection of current practice models, technological update and state-of-the-art management practices.

2. Comparative analysis of state and private health systems

There are significant differences between the two health systems: the state and private one. What is common refers to the interest of achieving optimum results. Both systems provide important performance, but the patient comfort, the satisfaction sources of the medical-sanitary and care personnel, policy of services differ globally. If we talk about organization, reception and accommodation conditions, we are referring to private medicine. If we talk about accessibility and the right to receive care, we are referring to the state medicine. The two systems must co-exist, providing currently the most reasonable formula of efficiency and quality increase in the Romanian health system. Table 1 summarizes a few comparative criteria between the state and private health system.

The model of private health services especially showed that performance medicine can be practiced in Romania and quality services can be provided by Romanian physicians.

Table 1. Comparison between state versus private health system (Ciurea, 2015a).

Analysis criterion	State health system	Private health system
Management and administration		
Financial support	Limited, with deficiencies	Maximum for each of targeted objectives
Medical and administrative equipment	Limited, with a few exceptions	Maximum in most units
Management activities	Low commitment for management activities in case of heads of clinics and physicians	High commitment for all personnel categories (management is important)
Authority	It depends on persons	It depends on the regulation
Addressability	Without limitation, any social and clinical category (emergencies, severe and chronic)	Segment selected on economic (those with financial status) and clinical criteria (mainly chronic)
Facilities	Limited	Multiple
Sterility	Circumstantial limitations	Maximum
Security of goods	Limited	Maximum
Clinical circuits	Sometimes with inconsistencies	It is strictly and always respected
Quality of services	It depends only on the ambition of specialists, not on standards	It depends on internal standards, the best specialists are recruited
Investments	The gain is reinvested in the development of institution and business	The official gain (e.g. for accommodation in rooms) is small and cannot be a reinvestment fund
Orientation toward the client		
Patient visit	Maximum (inefficient)	Limited (efficient)
Patient comfort	Limited	High (multiple facilities)
Accommodation conditions	Usual, public (overcrowding)	Rooms with maximum two beds
Confidentiality	The name of the patient is registered (name, diagnosis and treatment)	Maximum confidentiality
Waiting period	In whatever quantity (there	A few minutes (there is

Analysis criterion	State health system	Private health system
	is no preoccupation to reduce the waiting period)	the preoccupation to reduce the waiting period)
Patient privacy	It is not respected (the patient can be undressed, exposed to observers)	It is strictly respected (the patient cannot be undressed)
Patient labelling, discrimination	Possible	Excluded
Patient monitoring	Depending on circumstances	Mandatory (mediated and/or direct)
Communication with patient	Limited	Mandatory, optimum time interval
Patient satisfaction	Quantifiable after a reduced number of criteria	Quantifiable after many criteria
Auxiliary therapeutic services (counselling, kinetotherapy, massage, etc.)	Strictly necessary	Multiple possibilities
Clinical management		
Performance	Maximum, but there are also doubtful results	Maximum
Improvement	It depends on individual consent	It is institutional policy
Professional level	It depends on classification	Maximum, successful specialists are requested
Protocols	They are respected depending on circumstances	They are always respected
Work space	Limited (physicians without medical practices)	Calculated and sufficient
Interdisciplinary examinations	Limited, not supported from financial point of view by the institution	Overdeveloped, supported from financial point of view by the institution
Use of medication	Limited by financial flows	Maximum, the client has the necessary medicines
Resolution of complications	Only the physician is responsible for the patient	The entire team is responsible and involved
Malpractice	Possible, many cases of malpractice per system	Rigorously controlled, less cases of malpractice per system

Analysis criterion	State health system	Private health system
Personnel management		
Norms of personnel classification (personnel category distributed to a number of patients)	The norms are not complied with (insufficient personnel)	The norms are complied with (sufficient personnel)
Selection and evaluation of personnel	Formally carried out	Carried out with improvement methods
Labour behaviour and institutional culture	Arbitrarily	Written regulations and habits
Personnel identity	Vague (difficult to be identified, they do not wear name plates, reduced attachment)	Powerful identity (pride, identification, mandatory name plate)
Discipline	Circumstantial, sometimes limited	Uniform controlled at maximum level
Personnel outfit	Preferences are accepted	The strict standard is respected
Compliance with the work program	It is generally respected, there are degrees of liberty	Fixed program strictly controlled
Personnel conduct	Lightness (any manifestation is possible)	Strictly controlled, sanctions are applied
Work conditions	Limited	Very good (space for serving meals, buffet, locker rooms)
Work stress	Frequent (ambiguous resolution)	Prompt and efficient resolution
Respect	Circumstantial (probability of hostile expressions, courtesy, harassment)	It is mandatory (misconduct is analysed from disciplinary point of view)
Motivation	There is no motivational policy	There is motivational policy
Personnel payment	Insufficient	High
Informal payment	Existent	Absent
Conditioning of medical act	Possible	Excluded
Development		
Long clinical training	Maximum	Limited
Long operative training	Maximum	Limited
Medical education	Depending on options,	Always mandatory

Analysis criterion	State health system	Private health system
	sometimes limited	
Scientific research	Maximum interest, complex specialists and teams, sometimes with financial limitations	The research team is reduced from numerical point of view, collaborations are possibly preferred, the perspectives are more limited
Personnel appreciation		
Ethics of professional relations	Violation probability	No violation

The comparative analysis on criteria presented emphasizes the points in which the private health system managed to impose better practices or managed to solve a series of problems, which still persist in the state system.

3. Management principles in the private health system

There are certain differences between the private and state health system concerning at least the following aspects:

- *management concept*: the services represent a business, they must function exemplary in order to accumulate confidence capital, but also resources in order to maintain existing structures and develop them;
- *objectives*: a certain population niche is targeted, which wants certain health services or practices, however the extension of client-population is taken into account;
- *management processes and procedures*: the activities are highly regulated, organized according to quality management principles, with emphasis on detailed organization, on obtaining results in relation with high standards, maintenance of discipline and orientation toward client/patient.

Principle of responsibility. The measures to raise awareness of personnel for professional tasks are always applied in the private clinic. Responsibility is shared by management structures. All management processes are supported by the personnel with management functions (all categories). Responsibility is achieved by mechanisms such us: a solid system of *rules and procedures*; - *periodical verification* of technical systems, documents, results and reporting to higher levels; *detailed*

registration in documents; *frequent analyses* of management and operational, executive actions (strong points, weak points); *procedures of money saving* and waste prevention; *permanent information; personnel education for complying with work discipline; active safety and surveillance systems and access filters;* measures to correct misconduct.

Principle of orientation toward the client. The orientation toward the client/beneficiary is the most obvious tendency in the context of private health services. The patient is promptly approached, informed about what will happen, scheduled and maintained at high satisfaction level (which leads to loyalty, recommendation of the clinic to other clients). The orientation toward the client is carried out by: *educating the personnel in the relation with the client; increasing the visibility* of medical personnel and patient obligations; *permanent dialogue*, *treatment with respect*; *protocol for patient management in the clinic, in medical operations;*

Principle of dialogue and collaboration. A series of practices are applied in the private health system, such as: *dialogue and team cooperation* (meetings for debates), verification and mutual feedback (the subordinate level can verify certain actions and can suggest corrections to the management/secondary physician); *cooperation based on contract* (with specialists from other medical fields).

Principle of reward. The following rewarding modalities are applied in the private health system:

- *quantification of workload*: the list of examinations or actions can easily emphasize the occupation degree of the physician, which is paid accordingly.
- *quantification of worked time*: the presence registration cards provide a good quantification of work time. The overtime is fully paid.
- *predefined payment*: according to the contractual terms, each employee receives a predefined payment.
- *value recognition, appreciation manifestation*: the appreciation, open recognition of contributions, achievements is practiced more often in the private system.

Principle of emulation. In the private units, the management creates a state of enthusiasm due to the facilities provided by the organization to the personnel, due to exceptional equipment, work atmosphere and especially presence of selected medical personalities, who daily enter on the stage of

the clinic, playing their medical role at highest level. In the state system, emulation usually depends on preoccupations for development, excellence, sharing of news in the field, maintenance of professionalism and modern label.

The organizational culture in the private system is a well-structured culture, with declared values, visible symbols, carefully built and promoted practice and conduct rules. The solid organization is found at all levels, the valorization of a respectful environment, focused on performance and discipline (management has power, it is felt in any action) (Ciurea, 2015a).

4. Management directions in the relation with the patient and personnel

4.1. Satisfaction of patients/ clients

The private health services have the major objective of obtaining a very high level of client satisfaction. This objective correlates in a balanced way with aspects such as: business development, development of services, medicine development in itself.

The patient satisfaction represents a subjective multi-dimensional construct which indicates the personal evaluation provided by the patient to the medical services received in a unit. Satisfaction depends on certain frameworks or contexts and this is why it can have more dimensions or aspects.

In order to obtain patient satisfaction, the management of private health services takes into account the following aspects:

1. *reality and equity of transaction.* In essence, the patient is a consumer of medical services and goods. The patient-physician interaction is based on an economic transaction. The patient knows the cost of services and can find out if it is a correct and accessible price. Satisfaction results from:
   (a) the balance between what it receives in agreement with what it provides (Howard & Sheth, 1969);
   (b) relating the benefits received to a standard psychologically translated as set of expectations (Oliver, 1993).
2. *Regulation, clarification of expectations.* The physician discusses with the patient and helps him/her to see realistically the result of medical interventions. The risky situation of leaving uncertainties

and unclarified areas is avoided. The effect of expectations is influenced by other aspects such as: knowledge about requested service, context, degree of familiarization with that service, concept on expected results (Seceleanu, 2014).

3. emphasis of *health changes* through *objective measures.* The medical results must be quantified and presented to the patient. If the patient does not have the possibility to see the indicators of health improvement, he/she does not have satisfaction benchmarks (Kravitz et al., 2002).
4. *patient information in agreement with his/her need of information*. There are patients who need more information (some search on the Internet), others need less information or do not need any information. There is also the sample of those who avoid information, preferring not to ask more details in order not to become anxious. In this case, the family or next of kin information is carried out, followed by the decision related to what information and the manner in which it is communicated to the patient.
5. *care and openness attitude of the medical and auxiliary personnel*. Working with people always requires humane attitude. The patients appreciate a lot the relations characterized by humanism, not the formalized and distant relations in the clinic. The relation between patient and medical personnel (physician) is mediated by information provided to the patient, by the empathy with whom he/she was treated, by the specialized competence of the physician (Crow *et al.*, 2002).
6. *technical and material equipment*. The patients migrate to equipped units because they perceive the modern character of services and the increase of efficient treatment chances. Recently, many state units were modernized and they look very good. The private units have by definition very good technical and material equipment. The patient feels more secure in the units with modern equipment.
7. *availability of medical services or products*. Many patients prefer private health services in order to avoid possible unpleasant situations from state clinics: inexistence of medication and patient's need to purchase medicines or sanitary materials from the pharmacy across the health unit. Of course, this situation is very

rare, but it should not appear. The patient appreciates availability, but also quantity – the insufficient quantity of the product or service generates insatisfaction (there are medicines or materials, but not enough; the physician provides the examination but in short time; the procedure applied seems carried out on the run, etc.).

8. *access to necessary services*. There are geographical areas in which the state services do not cover the range of specialties. The private services can provide access and satisfaction in these areas.
9. *waiting period*. In a society in which the world functions against the clock, each person prefers the exact compliance with time. This is why the services that make appointments and comply with exact appointments are preferred. Even an approximate appointment or which is not fully complied with leads to insatisfaction.
10. *promptness*. In case of disease, the conservation instinct is the most important. The human being is very motivated to be helped as soon as possible in order to get out of the risky situation in which he/she is. Any quick service is highly appreciated. Any delay is detested. Even explanations or excuses do not solve the delay in case of a patient who needs a service. However, there is a useful partial practice for reducing insatisfaction related to reduced promptness: when the patient (who does not have crises in the moment of going to the physician) arrives at the medical practice, he/she is informed that it is possible to appear emergencies that will bring forward the schedule. It would be ideal that the patient is always approached promptly. The waiting period of the patient is regulated in private health services. If the physician or other employee exceeds the time limit, warnings will appear.
11. *coherence of actions* in which the patient is involved during the investigations and treatment. The patient notices the way in which the medical-sanitary personnel is organized for actions taken for the patient. Any inadvertency is labelled as organization problem or reduced competence. The universal solution is the very clear statement of procedures and the verification of their compliance.
12. *accommodation conditions.* Accommodation is one of the advantages of private health services. The emphasis is laid on the patient comfort in these services. Many persons prefer these services

due to the comfort during hospitalization. Accommodation has, in reality, many other details: illumination, air, space, the fact of being alone or not in the room, sound background, bed comfort, cleaning, painting, external image of unit, etc.

13. *general and specific cleaning*. Cleaning means hygiene and security. There is also a form of superficial cleaning which hides risks and which is excluded in the health services. The sanitation procedures are legally regulated. Generally, if omissions appear, these are related to details. An important aspect which the health units should solve is that of training the cleaning personnel, which is currently the employee of a company. There are situations in which the cleaning personnel does not know all details of the law and commits errors (dry sanitation of the room, starting the activity in inadequate moments disturbing other processes or actions of the operational personnel). In all cases, the deviations from the hygiene norms lead to major sanctions. The patient is a good observer and he/she always notices the degree or cleaning/hygiene.
14. *general attitude of personnel*. The balanced attitude is very highly appreciated (not very emotional, not very distant).
15. *administrative services*. The hospitalization and hospital discharge services are mostly used by the patient. Satisfaction appears when data processing is carried out quickly and the necessary documents are made available to the patient in reasonable time. Also, the interaction with the employees of these services is important for the final evaluation of patient satisfaction.
16. *food*. The quality and quantity of served food during hospitalization is a factor of patient satisfaction. The allocation for patient food is reduced in the state hospitals. Therefore, the meal is subcaloric and in limit quantity. In order to compensate this deficit, the patients or next of kin persons make additional shopping.
17. *personnel outfit*. The patient appreciates if the employees have neat and clean outfit. Especially in private services, the rules are very clear in this respect: indecent, unbuttoned, stained, unpressed, etc. outfits are not allowed (Seceleanu, 2014).

4.2. Communication with patient

Among the most important *communication principles* in the physician-patient relation, we mention:

- *principle of dialogue*: the physician and patient communicate, their meeting is not a monologue, the patient can ask questions, can manifest his/her ideas and opinions;
- *principle of collaboration*: the dialogue leads to mutual agreement decisions, in which the patient and his/her family assume the responsibility;
- *principle of assimilation*: the physician makes sure that the patient understood the information communicated, discussed within the dialogue in full knowledge;
- *principle of patience*: the physician treats the patient with patience, he/she gives him/her time to think in order to help him/her understand all treatment aspects and in no case rushes the patient if the intervention is not urgent;
- *principle of congruence*: the physician needs to obtain collaboration, he/she cannot force the moment of intervention or mode of treatment, he/she cannot take any actions if he/she does not have the patient consent, cooperation depends on the congruence of opinions and perspectives;
- *principle of compassion*: the compassionate attitude reduces stress, it shows that the physician is empathic and has a humane approach;
- *principle of respect*: we always treat the patient with respect, he/she is the client, beneficiary and must be treated as if he/she is our relative or the relative of one of our friends;
- *principle of complete information*: the patient is informed about the multiple aspects of treatment, recovery, the family can receive additional information when the patient does not have the capacity to fully understand the data (the consent must always be informed);
- *principle of regulation*: the dialogue physician-patient falls within legal, professional and ethical norms of the medical field (Ciurea, Pleș, 2015).

The right to a second opinion was differently adopted in health units as specialized service. In modern clinics, the physicians recommend the patient to also take into account the second opinion. In some hospitals, there is even an office or department which provides the second opinion. Therefore, the second opinion is an institutionalized service, recognized as such and promoted. In many clinics, the physicians consider that guiding the

patient to a second opinion is the recognition of personal professional incapacity. A series of consequences results from here:

- the physician prescribes a treatment in order to try to solve the patient symptoms or at least to improve them, not being certain of results and saying that they have to wait and see (!) how the patient reacts to the treatment.
- the surgeon operates the patient in his/her speciality preferring not to recommend another physician with other specialty (e.g., we mention the controversy between the orthopaedic surgery versus neurosurgical intervention in case of children with spastic paraparesis or spastic tetraparesis).

Thus, we all have the right to a second opinion in agreement with the principles:

- *principle of knowledge* – people must know what is happening to them, people must help others know what is happening to them.
- *principle of safety* – people have the right to fight for their safety, making sure that the intrusion in their body is based on the principle primum non nocere (first, do not harm).
- *principle of trust* – people say everything about them in front of the physician but the physicians must also say everything in order for the physician-patient relation to be characterized by honesty and trust.
- *principle of openness* – the physician has the obligation to explain all possible treatment alternatives, showing advantages and disadvantages. The patient is the decision-maker, he/she is the one who assumes the decision in full knowledge. Informed consent is the condition of managing health services. We can consult with other colleagues from the country or abroad. For example, for neurosurgery, we consult with colleagues from INI Center Hanover.
- *principle of satisfaction* – the patients must obtain the improvement of health state, perceive the real efforts which the sanitary system made in order to help them.
- *principle of modernization* – the physicians must develop not only the diagnosis and treatment competences, they must develop also the management of provided services, must create the culture of modern services, by adopting a certain type of attitude which translates

openness, preoccupation, care and even attachment (Ciurea, Pleş, 2015).

4.3. Medical career and management of human resources

Finding development opportunities of medical career in private units can be an efficient solution that brings with it the saving of resources, increase of involvement degree of resident physician, retention of medical personnel in the country, involvement of the clinic in actions that have subsequent significant benefits. Recent statistics show that many physicians no longer want to work for the state or the Romanian health system. Annually, more than 2.000 physicians leave Romania to work in medical practices, clinics and hospitals from other countries. According to the information made public by the College of Physicians, in the last six years, over 15.000 physicians left voluntarily the Romanian health system (Ciurea, 2015b).

Many physicians chose the career in the private health system for the following reasons: correct payment, respect, adequate equipment, organization efficacy, time management, social appreciation, balance between work – personal life, feeling of coherence and professional fulfilment.

A promising development perspective of the Romanian health system is the residency in private clinics. Programs with very precise specifications of training stages can be elaborated: competences to be formed, activities, consultation of handbooks, etc. In the private network, the use of resident physicians can be a good selection basis (the selection of the best, the detailed testing of abilities and conduct, graded grant of responsibilities, etc.). The use of resident physicians can be economical. They can be involved in many operations and their payment is provided by the state, the private unit following to allocate additional compensations according to the activity performed.

The career of the medical personnel in the private clinic is more motivating due to the modern organizational culture and management practices, which include:

- daily activity program established,
- time dosage so that there is clinical, operative, research activity (practice with responsibility, supervised practice),
- adequate spaces for breaks, training, relaxation,
- flow of patients with different pathologies,

- grouping a reduced number of resident physicians per training physician,
- application of efficient practices for the management of files,
- access to equipment with high performance level and excellence projects;
- existence of rigorous norms in agreement with the activity norms of that unit;
- fair and clear payment per case and per services;
- efficient personnel coverage;
- balanced distribution of personnel per services;
- efficient financing of services;
- negotiated collaboration as duration and payment;
- partnership relations, including the openness to cooperation with physicians from the state system for treatments/special surgical interventions.

The management of human resources includes activities of: personnel recruitment and selection, personnel integration, personnel evaluation, personnel motivation, collaboration conclusion. All of these activities are managed according to modern principles and practices (Zeuch, 2016).

The professional integration is a systematic, *programmed* process so that the results are periodically evaluated. Management takes into account the efficient personnel integration in the assembly of operations, the creation of the feeling of affiliation and motivation for performance. *The procedural, professional* but also *organizational* learning (rules, habits) is facilitated in the integration period. The adaptation to tasks, procedures, working rhythm, institution rules, leadership style adopted by management/leaders, network of formal and informal relations, modes of making decisions and actional models, values and organizational culture (habits, traditions, values, practices) is ensured in the period of professional integration.

5. Conclusions

At global level, the private system has a series of advantages that do not appear in the state system. It is instituted as benchmark of administrative, locative and organizational quality. The private system ensures its record of successes and appreciations through the careful selection of the personnel and involvement of important specialists. Although the state system has its valuable human capacity and large

organizational structure, it still has a large number of problems that affect its functionality and maintain it prone to risks.

The relation between the two health systems, the state and private ones, must be equally characterized by competition and complementarity. The two health systems compensate each other, bringing on the market a better balance of the offer of health services necessary for the population. The introduction of private health services must not be an objective in itself, but the objective is to register real benefits for the population health and social and economic system.

References

1. Ciurea, A.V., Ciubotaru, V.G., Avram, E. (2009). Management modern în organizaţiile sănătăţii. Perspective in serviciile de Neurochirurgie, Bucharest: University Publishing House.
2. Ciurea, A.V. (2015a). *Dezvoltarea sistemului de sănătate privat*. In A.V. Ciurea, H. Pleş, E. Avram (Eds.) (pp. 25-38). Managementul în sistemul de sănătate privat. Bucharest: University Publishing House.
3. Ciurea, A.V. (2015b). *Dezvoltarea carierei medicale în sistemul de sănătate privat*. In A.V. Ciurea, H. Pleş, E. Avram (Eds.) (pp. 57-74). Managementul în sistemul de sănătate privat. Bucharest: University Publishing House.
4. Ciurea, A.V., Pleş, H. (2015). Comunicarea cu pacientul. In A.V. Ciurea, H. Pleş, E. Avram (coord.), *Managementul în sistemul de sănătate privat*. pp. 147-166, Bucureşti: University Publishing House.
5. Crow, R., Gage, H., Hampson, S., Hart, J., Kimber, A., Storey, L. & Thomas, H. (2002). The measurement of satisfaction with healthcare: implications for practice from a systematic review of the literature, *Health Technology Assessment*, 6(32): 1-244.
6. Kravitz, R.L., Bell, R.A., Azari, R., Krupat, E., Kelly-Reif, S., Thom, D. (2002). Request fulfilment in office practice: antecedents and relationship to outcomes. *Medical Care*; 40(1): 38-51.
7. Oliver, R.L. (1993). Cognitive, affective, and attribute bases of the satisfaction response. *Journal of Consumer Research.* 20, 418-430.
8. Seceleanu, V., (2014). Satisfacţia pacientului în unităţile private de sănătate. In A.V. Ciurea, H. Pleş, E. Avram (Eds.), *Managementul în sistemul de sănătate privat* (pp. 147-166), Bucharest: University Publishing House.
9. Zeuch, M. (Ed.). (2016). *Handbook of Human Resources Management*. Springer.