International Journal of Economic Practices and Theories, Vol. 4, No. 5, 2014, Special issue on Marketing and Business Development, e-ISSN 2247–7225

www.ijept.org

A Comparative Multicultural Study of Patient Satisfaction in the European Union

by
Mădălina-Alexandra Coțiu, Horațiu Sorin Dan
Babeș-Bolyai University, Faculty of Economics and Business Administration
Babeş-Bolyai University, Faculty of Electrical Engineering
madalina.cotiu@gmail.com, dan.horatiu.sorin@gmail.com

Abstract. Patient satisfaction is increasingly regarded as an important element in healthcare systems management and reforms. It has become even more important in the context of increasing competition because of the rapidly developing private clinics, an increasingly ageing population, complex healthcare system reforms and increased public scrutiny. This has led to a series of studies, reports and surveys being conducted all over Europe in an attempt to identify and rank those factors affecting satisfaction and identify strategies for the development and improvement of European healthcare systems. However, very few of the studies considered the impact cultural elements have on patients` answers, rankings and evaluations of their satisfaction and healthcare systems. The article takes on this challenge and aims to identify and discuss the impact cultural elements have on perceived patient satisfaction with the goal of suggesting marketing and business development solutions and further research ideas. The research was conducted through secondary data analysis based on a set of several studies dealing with patient satisfaction with healthcare. Data has then been discussed considering the cultural dimension of the European Union (EU) countries selected for this analysis. Results show that satisfaction levels vary among EU countries and are influenced by the different cultural dimensions. It is our belief that healthcare system reforms and evaluations should be market oriented and should closely consider cultural particularities, while at the same time remaining committed to delivering high quality medical services across the EU, thus reducing disparities between healthcare systems and how they are perceived in different Member States.

Key words: patient satisfaction, cultural values, EU countries, multiculturalism
JEL classification: I11, M31, Z190, H4.

1 Introduction

As countries all over the world are facing the challenge of ageing population and increased health expenditure, patient satisfaction has been increasingly regarded as an important element to consider when discussing health care management and reform strategies, be they at an international, national, local, or even unit level. Yet, researchers find it difficult to agree on a common definition of what patient satisfaction is, or on the set of factors determining it (Bleich *et al*, 2009; Sitzia and Wood, 1998; Wolf *et al*, 1978; Taylor and Benger, 2004; Gill and White, 2009). For the purpose of this study we choose to use the definition proposed by Hjortdahl and Laerum (1992, p. 1287) that patient satisfaction is a set of "complex relations between the patient`s perceived needs, expectations and experience of care; the particular reaction to the consultation and its outcome, relative to a conscious or subconscious standard that the patient had set before or during the encounter". This means that patient satisfaction is a subjective evaluation of the health care service based on needs, expectations and the experience of care. In order to reach a higher degree of understanding on patient satisfaction, numerous studies have attempted to identify, select or rank patient satisfaction determinants, often with conflicting results. Studies suggest determinants may be factors such as demographic or visit characteristics (Boudreaux *et al*, 2000; Fitzpatrick and Hopkins, 1983; Quintana *et al*, 2006) while others also discuss the effect of expectations or personality traits on the satisfaction levels of different groups of patients (Gill and White, 2009; Bleich *et al*, 2009). Researchers also consider groups of patients differently, focusing on in/outpatients, adults or pediatric patients, emergency department cases or patients suffering from chronic illnesses (Magaret *et al*, 2002; Taylor and Benger, 2004). However, very few of these studies present a

comparative analysis across settings or countries and almost none seem to take into consideration the manner cultural differences among countries could affect the satisfaction levels reported by patients.

Research in this area is especially important as national health systems are ranked across smaller or larger regions and even continents. Rankings then contribute to funding allocation and impact on the country`s image in the national and international media (Taylor and Blackstone, 2012). This occurs in a context of sustained pressure on health expenditure determined by an ageing population, increased scrutiny on public spending, the introduction of new technology and the recurrent competing goals of lowering costs while offering high quality services (Aiken *et al*, 2012; Kotzian, 2009; Calnan, 1997). Furthermore, research on patient satisfaction is also strongly encouraged by the European Commission (EC) and the World Health Organisation (WHO) which asked for more responsiveness to citizens expectations as a valued and desired outcome of healthcare system performance (Aiken *et al*, 2012, European Observatory on Health Systems, 2012).

Recent research also emphasizes a shift in patients` expectations from their healthcare system. Studies suggest that citizens in developed countries are less prone to declare themselves satisfied once the primary goal of healthcare, that of restoring health, has been achieved (Kotzian, 2009; Bleich, 2009). As the goal of restoring health often appears to be taken for granted in these countries, patients now seem to be deriving their satisfaction from "beyond health outputs" such as respect for their autonomy, dignity and intimacy or the degree of emotional support they received (Kotzian, 2009; Bleich, 2009).

Another aspect worth considering relates to the particular characteristics of the patient population, namely their value systems, the way healthcare is perceived in their culture, the role and social status associated with healthcare professionals and even the level of consumerism of the society (whether patients are passive or they tend to act as consumers) (Baron-Epel *et al*, 2001). Patient satisfaction scores can also be affected by the media portrayals of the healthcare system, the manner in which the system is discussed by the political leaders (Osatuke *et al*, 2009).

Furthermore, scholars suggest the existence of a particular set of factors affecting patient satisfaction in countries having a healthcare system in transition. For example, such factors could include a more positive evaluation of the healthcare received if patients identify positive changes in the system (Bara *et al*, 2002).

The added value of this article lies in the fact that it puts forward a comparative analysis of patient satisfaction levels in six EU countries and discusses the results in connection with the cultural particularities of the selected countries. This is important in the context of a culturally and economically heterogeneous EU, marked however by efforts of integration and homogenization that do not leave out the medical sector. A relevant step forward in this direction is the facility that patients with government covered insurance opt for treatment in another Member State, while the government picks up the bill (EC, 2013). Consequently, understanding how patient satisfaction is expressed by focusing on the cultural perspectives of the patients and trying to eliminate economical factors linked to the objective quality of the medical performance (like total expenditure in health, expressed either per capita, either as percentage of GDP) is crucial in drafting an effective and efficient strategy for an EU wide healthcare system.

The study further aims at helping build a base for future research in the area of cultural influences on patient satisfaction. We believe, broader understanding on how cultural factors affect patient satisfaction will assist policy makers, healthcare facilities managers or international organizations in comparatively ranking healthcare facilities within the same country and across countries in a consistent manner. This is of outmost importance as rankings guide citizens in choosing a certain medical facility, comparing associated costs or opting for treatment in a different country, as well as influencing financing.

2 Methodology

The research is a pilot study conducted for six European Union countries: Romania, Poland, The United Kingdom, Lithuania, Finland and Greece. The countries were selected in order to be representative for the major areas in the European Union (Northern, Southern, Western, Eastern and Central EU). The research was conducted through secondary data analysis based on ten studies on patient satisfaction conducted at national or international level between 2007 and 2013. The main sources of data were reports of the World Health Organization, the World Bank, The European Union through Eurostat and IRIS Network as well as several national studies on patient satisfaction.

Data were analyzed comparatively considering the following parameters for each country: population, GDP/capita, life expectancy, healthcare national spending, perceptions on health status, perceptions of the healthcare system, its issues and funding as well as healthcare satisfaction and quality indicators for primary and hospital care.

Data were then analyzed in relation to specific cultural particularities of the six countries. The characteristics considered are among those identified by Hofstede (2011) and include: uncertainty avoidance and the tolerance of ambiguity, power distance, seen as the degree to which people accept a given hierarchical order (The Hofstede Centre), pragmatism, which measures how individuals "relate to the fact that so much that happens around us cannot be explained" and their need to explain the mechanisms and phenomena that influence their lives. A low score will show the desire to explain as much as possible, while a pragmatic culture will tend to focus on what they can understand and not to seek explanations for things perceived to be too complex **(**The Hofstede Centre).

The article is mainly aimed at scholars in the fields of marketing and healthcare, as well as at policymakers interested in an overview of the relation between satisfaction ratings with healthcare and cultural particularities of European Union countries.

The added value of the article resides in that it presents a broader analysis of the factors influencing satisfaction and healthcare system ratings beyond health outputs. In our view, this contributes to a better understanding of the processes behind citizen`s judgments on quality and satisfaction and offers policymakers a starting point for further analysis. Moreover, the discussion we propose also raises some interesting points with regard to the appropriateness of healthcare system ratings based on questionnaires not considering differences in attitudes in the various Member States.

The specific objectives of the article are therefore to:

a) identify cultural elements having an impact on perceived patient satisfaction in several European Union countries;
b) discuss marketing and business development implications for the healthcare sector resulting from this analysis;
c) suggest further research areas in the field of cultural influences on patient satisfaction.

3 Results

A summary of the six selected countries in terms of population, GDP/capita and total expenditure on healthcare (per capita and as percent of GDP) is given in table 1.

Table 1. Summary of selected healthcare indicators

Country	Total pop. (mil.)	GDP/ capita (2012) US $	Total expend. on health/ capita (2011) US $	Total expend. on health as % of GDP
Romania	21,75	8.437	902	5,8
United Kingdom	62,76	38.920	3.322	9,3
Greece	11,1	22.456	2.918	10.8
Lithuania	3,02	14.172	1.337	6,6
Poland	38,21	12.710	1423	6,7

Finland	5,4	45.723	3.332	8,9
EU (27 countries)	501,4	32.021	2.171	9

The table was compiled by the authors based on data available form the World Health Organisation (http://www.who.int/countries/en/), the World Bank (http://data.worldbank.org/indicator/NY.GDP.PCAP.CD) and the Economy Watch (http://www.economywatch.com/economic-statistics/economic-indicators/GDP_Per_Capita_PPP_US_Dollars/2012/)

One can easily notice that considerable disparities exist in terms of healthcare spending between the selected countries. Although the third country in terms of population, Romania has the lowest GDP/capita and the lowest healthcare spending/capita among the six countries. Also, apart from the Central and Eastern European countries which spend between 5.8 and 6.7% of their GDP on healthcare, the other countries spend more than 8%, with Greece allotting the highest percent (10.8%).

In terms of healthcare indicators, a summary of the countries considered is presented in the table below.

Table 2. Healthcare indicators

Country	Life expectancy at birth m/f	Perceived personal health assessment scores (Excellent/Good)
Romania	71/78	17/72 = 83
United Kingdom	79/83	12/69 = 81
Greece	78/83	15/72 = 87
Lithuania	68/80	20/69 =89
Poland	73/81	6/56 = 62
Finland	78/84	8/63 = 72
EU (27 countries)	75.3/81.7	-

The table was compiled by the authors based on data available from the World Health Organisation (http://www.who.int/countries/en/) for each country and the IRIS Global Health Survey, 2011.

Life expectancy at birth in the European Union (27 countries) ranges from 68 to 78 years for males and 78 and 84 years for females. The lowest life expectancy rates were registered in Lithuania for males and Romania for females. In spite of this, Lithuanians rank first with regard to the perceived personal health assessment, with a total score for excellent or good health of 89. They are followed by Greece (total score: 87) and Romania (total score: 83). Although with considerable higher spending on healthcare and with better life expectancy rates the Finnish only scored 72 for their health status as excellent or good.

Moreover, with regard to the perception of the healthcare system in general (IRIS 2011; EC 2009), the worst perceptions were identified among Romanians, Greeks and Polish. Only 25% of Romanians and Greeks and 30% of Polish regarded the healthcare system as good, as opposed to 86% of the British and 94% of the Finnish. It is no surprise that 38% of the British and 55% of the Finnish also considered their health system as better than those in other countries, while the great majority of Romanians (73%), Greeks (77%) or Polish (63%) regard their system as worse than in other countries (IRIS 2011; EC 2009).

Taking a closer look at the data, we can spot a series of discrepancies between reality and perception. First of all, the people that have the short life expectancy (Romanians and Lithuanians) consider themselves healthier than Finnish or British for example, who live longer. What adds to the mystery is that at the same time these people are less satisfied with their national medical systems (Table 3), a perception that is consistent with levels of health expenditures in each country. Second, the Greeks, who enjoy both healthcare expenditures (per capita and as a percentage of GDP) and life expectancy that are better than the EU27 average, indicators which correctly translate into a self perceived high personal health assessment, do not regard their medical system as being able to deliver good quality of services. Indications of what lies behind the differences in the way medical systems are perceived can be found by studying the cultural characteristics of each country. Table 3 summarizes the way in which each of the considered countries (or, to be more precise, their cultures) score across

several cultural dimensions. Note that, when analyzing these scores, it is important to bear in mind that they are relative and that they are to be interpreted by comparison (The Hoftede Center).

Table 3. Evaluation of national cultural characteristics (The Hofstede Center)

Country	Uncertainty avoidance	Pragma -tism	Power Distance
Romania	90	52	90
United Kingdom	35	51	35
Greece	100	45	60
Lithuania	65	82	42
Poland	93	38	68
Finland	59	38	33

The table was compiled by the authors based the Hofstede Centre http://geert-hofstede.com/countries.html

As it can be easily observed, a great deal of cultural heterogeneity exists between the considered countries, heterogeneity that may contribute in explaining differences in perception.

Our first observation is linked to the connection between healthcare system quality perception and cultural characteristics. If in the case of Polish and Romanians the negative assessment of the medical system is most likely due to the low levels of financing, the Greek situation is fundamentally different, as Greece investments in healthcare are, out of the considered lot of countries, the highest as percentage of GDP and third highest as per capita amount, and in the same time much higher than the EU27 average. Nonetheless, Greek patients exhibit a high level of dissatisfaction with the quality of their medical system, a perception that can be correlated with the high degrees of uncertainty avoidance and low relative pragmatism. Indeed, as health and the results of medical care are inherently uncertain, while healthcare processes can often prove to be complex and difficult to understand, the more critic Greek attitude is consistent with their cultural traits.

Following similar mechanisms, we turn our attention towards the perceptions of Polish patients, whose difficulties when having to deal with uncertainty are doubled by a relatively non-pragmatic attitude, thus making them more pessimistic when it comes to evaluating their own health. This is despite the fact that they live longer than Romanians and Lithuanians. This is also true for Finish patients who, although enjoying a well-funded healthcare system that correlates positively with high life expectancy, are culturally influenced by low pragmatism and oriented towards an overly pessimistic perception of their individual health. At the same time, relatively high pragmatism and medium tolerance to uncertainty, as is the case of Lithuanian patients, translate into a high score of the perceived personal health assessment, despite lower than average life expectancy and healthcare system financing.

Consequently, we can draw the conclusion that these healthcare related perceptions are influenced not only by objective factors, such as investments in infrastructure and statistic life expectancy, but also by a series of subjective culturally driven elements, such as uncertainty avoidance and pragmatism. Moreover, we can note that both uncertainty aversion and the normative view associated to the lack of pessimism positively influence pessimism when it comes to evaluating health and healthcare.

The most positive situation of the six countries under analysis is found in the United Kingdom where all factors (healthcare investments, life expectancy and patient satisfaction) rank high and are closely correlated. This proves that a constant attention given to the functioning of the NHS and patient satisfaction (NHS Survey, 2013) together with appropriate resource allocation can lead to positive healthcare results. This may also be the result of a public system culturally focused on customer care, a system that emphasises the customer service ethos as it exists to serve the people (Koumenta, 2009).

In terms of the public perception of the healthcare system in general, the reports suggest a general perception of a system in crisis mainly due to poor management and underfinancing (IRIS, 2011). This is also true for countries where the system as a whole is mostly perceived as good (Taylor, 2012; Appleby, 2011; IRIS 2011; EC, 2009). Table 4 presents a

synthesis of satisfaction levels with hospital and primary care as main dimensions of the healthcare services.

Table 4. Satisfaction with hospital and primary care

Country	Good hospital care (%)	Accessi-ble hospital care (%)	Affor-dable hospital care (%)	Good family physi-cian (%)
Romania	42	63	45	71
United Kingdom	77	80	26	88
Greece	48	70	55	73
Lithuania	57	65	54	77
Poland	42	69	79	73
Finland	88	70	78	81
EU (27 countries)				84

The table was compiled by the authors based on the Special Eurobarometer 283 (2007) and 327 (2009).

What is interesting to notice is that the family physician is very positively regarded. Even in countries where the public is generally unsatisfied with the healthcare system and the public system in general (Jankauskiene and Jankauskaite, 2011, Voinea and Pamfilie, 2009), the family physician scores high satisfaction ratings (for all countries, satisfaction scores for the family physician are above 70).

Another point of analysis was the patients` desired input into treatment decisions. The existing literature (Williams *et al*, 1998, Haug and Lavin, 1981, Krupat *et al*, 2000; Mead and Bower, 2000) suggests this is a significant trend in the sense of increased interest in patient-centred medicine and is at this time a more middle aged, mid/upper class, better educated phenomenon (IRIS, 2011).

Table 5. Patient input into treatment decisions and funding preference

Country	Patient input into treatment decisions (Patient/Toge-ther with Physician/Physi-cian only)	Funding preference (Government /Private)
Romania	8/28/64	82/18
United Kingdom	9/61/28	82/9
Greece	6/63/31	81/16
Lithuania	14/30/53	83/14
Poland	8/64/26	74/21
Finland	5/62/33	78/12

The table was compiled by the authors based on the results of the IRIS Global Health Survey, 2011.

From a cultural perspective, the high satisfaction with the family physician can be attributed to the high scoring of the power distance attribute (90), as calculated by the Hofstede Centre, a score that translates into a high degree of acceptance of hierarchical order. In the direct relationship between physician and patient, the hierarchical superiority of the former is implicit and this, correlated with the high respect for hierarchy, could explain why Romanians are satisfied with their physician while transferring their dissatisfaction towards a non-personalized healthcare system that is not part of any hierarchical relationship but a mere environment whose perceived flaws translate into with barriers that regarded as objective and that hinder the medical act, in the detriment of both patient and physician. High satisfaction levels with the family physician can also be attributed to the fact that patients see them for a long enough period of time so that they can build a relationship with the doctor. Research shows that continuity of care can increase the chances of a positive evaluation of the medical service interaction up to seven times (Hjortdahl and Laerum, 1992).

The effects of attitude towards hierarchy are also visible when it comes to the patient's input into treatment decisions (Table 5). Also this is visible in the case of Romanian patients who have, even when it comes co-deciding together with the physician, a low relative involvement in treatment decisions, a behavior that is clearly linked to their high power distance score.

In terms of a general view on patient satisfaction determinants across the six countries, these appear to fit the same general categories identified in the literature, although with some specific differences. For example, in

the case of Romania, informal payments pay a considerable role in influencing patient satisfaction. Also, in the case of Romanians choosing to benefit from a medical service in private clinics, one of the most important influencer of their satisfaction is the equipment used (Șomănescu, 2011). The system limitations also appear to be influencing satisfaction to a great extent, especially in the case of older, lower income patients (Coțiu *et al*, 2014). In the case of Poland, increased emphasis is placed on factors such as the material area, namely the living conditions for inpatients, but also on the degree of empathy showed by the medical staff and the way they communicate with patients (Rosiek and Leksowski, 2012). For the United Kindgom and Finland, emphasis is placed on a variety of factors such as interactions, attention given to family and friends, nursing care, physician care and staff care, but also on factors beyond the immediate health outcome such as the privacy of the triage area, the intimacy the patient benefits from or the respect shown for its dignity (Taylor, 2012; Magaret, 2002).

4 Limitations

The limitations of this paper were mostly determined by the access to data. Considerable differences exist in the number and type of studies on patient satisfaction conducted across Europe. While some countries such as the United Kingdom conduct patient satisfaction studies on a constant basis, other countries only do so occasionally and rarely have studies covering the entire population. This made data gathering more complicated. However, we believe the reposts used for this analysis present a relevant image of the six countries in terms of healthcare characteristics.

Also, since culture is determined by a large number of interconnected characteristics, which all cast their influence on individual perception, the restriction of the scope of cultural characteristics considered that is inherent to any model may simplify links between factors and their effects. This is however not to be understood as something that undermines the validity of the identified links between cultural characteristics and patient perceptions, but just as a reminder that other factors may also contribute to the formation of the expressions of patient satisfactions.

5 Conclusions

In conclusion patient satisfaction and their perception of the various healthcare dimensions such as individual health and the national healthcare system goes beyond objective realities, and taps into the patient's culture. Indeed, cultural attitudes prove to have real effects on patient perceptions, as the results of the study suggest that cultural elements can generate perceptions that prove to be inconsistent with life expectancy or the level of healthcare system investments. Consequently, when drawing up the healthcare strategy, the entities involved, both public and private, should take cultural elements into consideration and include them into their marketing approach if they are to promote a fully effective and efficient business development model. Furthermore, from a research point of view, we strongly recommend closely considering country characteristics when drafting research methodologies aimed at measuring patient satisfaction or identifying patient satisfaction determinants. Not considering such aspects may result in the overlooking of important elements that will then affect research implications for business development, international rankings or funding allocations.

Last but not list, we strongly believe that adding the cultural dimension to any patient satisfaction research offers a broader view on this complex, multidimensional concept and facilitates scholars and business professionals understanding of it.

Acknowledgement

This work was cofinanced from the European Social Fund through Sectoral Operational Programme Human Resources Development 2007-2013, project number POSDRU/159/1.5/S/142115 „Performance and

excellence in doctoral and postdoctoral research in Romanian economics science domain".

References

Appleby, J. (2011), How satisfied are we with the NHS?, *British Medical Journal*, 342, doi: http://dx.doi.org/10.1136/bmj.d1836

Bara, A.C., Heuvel, W.J.A., van den, Maarse, J.A.M., Dijk, J.P. van (2002), Users` satisfaction with the Romanian health care system: an evaluation of recent healthcare reforms, *European Journal of Public Health* [online] 12(4): 39-40 (Supplement), http://pubproxy.ub.rug.nl/1/dissertations/FILES/faculties/medicine/2003/a.c.ionila/c5.pdf, Accessed 15 January 2012.

Baron-Epel, O., Dushenat, M., Friedman, N. (2001), Evaluation of the consumer model: relationship between patients` expectations, perceptions and satisfaction with care, *International Journal for Quality in Health Care*, 13(4): 317-323, http://www.ncbi.nlm.nih.gov/pubmed/11560351, Accessed 15 March 2014.

Bleich, S. N., Özaltin, E., Murray, C. J. L. (2009), How does satisfaction with the health-care system relate to patient experience?, *Bulletin of the World Health Organisation* [online] 87(4): 271-278, http://www.scielosp.org/pdf/bwho /v87n4/v87n4a12.pdf, Accessed 14 August 2013.

Boudreaux, E. D., O`Hea, E. L. (2003), Patient Satisfaction in the Emergency Department: A Review of the Literature and Implications for Practice, *The Journal of Emergency Medicine*, 26(1): 13-26, http://www.osuem.com/journal_club/articles/boudreaux_review_2004_pgy1.pdf, Accessed 16 August 2013.

Coțiu, M A (2014) Consumer Satisfaction in the Healthcare Sector. A Critical Review of Some Empirical Studies, *International Journal of Economic Practices and Theories*, 4(2), http://www.ijept.org/index.php/ijept/article/view/Consumer_Satisfaction_in_the_Healthcare_Sector_A_Critical_Review_of_Some_Empirical_Studies/118, 3 April 2014.

European Commission (2007), *Special Eurobarometer 283: Health and long-term care in the European Union*, http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf, Accessed 13 March 2014.

European Commission (2009), *Special Eurobarometer 327: Patient Safety and Quality of Healthcare*, http://ec.europa.eu/public_opinion/archives/ebs/ebs_327_en.pdf, Accessed 13 March 2014.

European Commission (2013), *Planned Healthcare*, http://europa.eu/youreurope/citizens/health/planned-healthcare/index_en.htm, Accessed 3 April 2014.

Fitzpatrick, R. and Hopkins, A. (1983), Problems in the conceptual framework of patient satisfaction research: an empirical exploration, *Sociology of Health and Illness*, 5(3): 297-311, http://onlinelibrary.wiley.com/doi/10.1111/14679566.ep10491836/pdf, Accessed 16 August 2013.

Gill, l. and White, L. (2009), A critical review of patient satisfaction literature, *Leadership in Health Services*, 22(1): 8-18, http://xa.yimg.com/kq/groups/18751725/221284563/name/A%252BCRITICAL%252BREVIEW%252BON%252BPATIENT%252BSATISFACTION.pdf, Accessed 17 August 2013.

Haug, M.R., Lavin, B. (1981), Practitioner or Patient – Who`s in Charge?, *Journal of Health and Social Behaviour*, 22(3): 212-229, http://www.jostor.org/stable/2136517, Accessed 3 April 2014.

Hjortdahl, P and Laerum, E. (1992), Continuity of care in general practice: effect on patient satisfaction, *British Medical Journal*, 304: 1287-1290, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1881840/pdf/bmj00073-0037.pdf, Accessed 17 August 2013.

Hofstede, G. (2011) Dimensionalizing Cultures: The Hofstede Model in Context, *Online Readings in*

Psychology and Culture, 2(1), DOI 10.9707/2307-0919.1014, Accessed 2 May 2014.

IRIS Market Research (2011), *Global Health Survey – Experience and Perception in 28 Countries*, http://www.arc.com.pl/download.php?id=2, Accessed 3 March 2014.

Koumenta, M. (2009), *Modernisation, Privatsation and the Public Service Ethos in the UK*, http://cep.lse.ac.uk/conference_papers/14_12_2009/Koumenta.pdf, Accessed 3 April 2014.

Krupat, E., Rosenkrantz, S.L., Yeager, C.M., *et al* (2000), The practice orientations of physicians and patients: the effect of doctor-patient congruence on satisfaction, *Patient Education and Counseling*, 39(2000): 49-59, http://www.floppybunny.org/robin/web/virtualclassroom/comms/models/articles/doctor_patient_congruence_2000.pdf, Accessed 13 March 2014.

Magaret, N. D., Clark, T. A., Warden, C. R. *et al* (2002), Patient Satisfaction in the Emergency Department – A Survey of Paediatric Patients and Their Parents, *Academic Emergency Medicine*, 9(12): 1379-1387, http://onlinelibrary.wiley.com/doi/10.1197/aemj.9.12.1379/pdf, Accessed on 14 August 2013.

Mead, N., Bower, P. (2000), Patient-centeredness: a conceptual framework and review of the empirical literature, *Social science & medicine*, 51(7): 1087-1110, http://med.over.net/javne_datoteke/novice/datoteke/312-reading25cPatientccentrednesscacconceptualcframework1.pdf, Accessed 13 March 2014.

NHS Surveys 2013, http://www.nhssurveys.org/, accessed 3 April 2014.

Osatuke, K., Fishman, J., Moore, S.C., Dyrenforth, S.R. (2009), Relationship between Portrayals of VA Hospitals in the Media, and Employee and Patient Satisfaction: An Exploratory Analysis, *Paper presented at the annual national conference of the American Association for Public Opinion Research*, 15 May 2009, http://www.amstat.org/sections/srms/proceedings/y2009/Files/400012.pdf, Accessed 11 March 2014.

Quintana, J. M., Gonzales, N., Bilbao, A. *et al* (2006), Predictors of patient satisfaction with hospital health care, *BMC Health Sciences Research*, 6: 102-111, http://www.biomedcentral.com/1472-6963/6/102, Accessed 16 August 2013.

Șomănescu, C. (2011), De ce merg românii să se trateze în clinicile private, *Money.ro*, 9 mai 2011, http://www.money.ro/de-ce-merg-romanii-sa-se-trateze-la-clinicile-private_955096.html, Accessed 3 April 2014.

Taylor, C. and Benger, J.R. (2004), Patient satisfaction in emergency medicine, *Emergency Medicine Journal*, 21: 528-532, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1726409/pdf/v021p00528.pdf, Accessed 16 August 2013.

Taylor, A. (2013), The British Are Surprisingly Satisfied With Their Controversial Socialized Health Care System, *Business Insider*, 10 September 2013, http://www.businessinsider.com/british-satisfied-with-nhs-2013-9, Accessed 3 April 2014.

Taylor, A., Blackstone, S. (2012), These Are The 36 Countries That Have Better Healthcare Systems Than The US, *Business Insider*, 29 June 2012, http://www.businessinsider.com/best-healthcare-systems-in-the-world-2012-6?op=1#!H9zy3, Accessed 3 April 2014.

The Hofstede Centre, http://geert-hofstede.com, Accessed 2 May 2014.

Voinea L, Pamfilie R (2009), Considerations Regarding the Performance Improvement of the Hospital Healthcare Services from Romania by the Implementation of an Integrated Management System. *Amfiteatrul Economic* XI(26): 339-345, http://www.amfiteatrueconomic.ro/temp/Article_874.pdf, Accessed 3 April 2014.

Williams, S., Weinman, D, Dale, J. (1998), Doctor-patient communication and patient satisfaction: a review, *Family Practice*, 15:480-492, http://www.researchgate.net/publication/13440195_Doctor-patient_communication_and_patient_satisfaction_a_review/file/5046351c8b85ebf07c.pdf, Accessed 3 April 2014.

Author description

Mădălina-Alexandra Coțiu is a Phd student at the Babeș-Bolyai University in Cluj-Napoca, Romania. Her research interests belong to the field of Marketing with a particular focus on consumer satisfaction and customer service.

Horațiu Sorin Dan, PhD in Economics and International Business from the Babeș-Bolyai University in Cluj-Napoca, Romania, currently focuses his research on how cultural differences can affect the socio-economic environment within the European Union.