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Customer Satisfaction and Perception of Healthcare Service: A case study in Takeo Referral Hospital

[1]Mr. Seng Raksmey, [2]Mr. Xu Huaifu

[1]Department of Business Management, School of International Pharmaceutical Business, China Pharmaceutical University (CPU), China.

[2]Associate Professor, School of International Pharmaceutical Business, China Pharmaceutical University (CPU), China.

Abstract: **Patient satisfaction is a measure of the extent to which a patient is content with the healthcare they received from their healthcare provider. Patient satisfaction is one of the most important factors to determine the success of a healthcare facility. The findings of the study are gleaned by using regression to explore patient satisfaction with the healthcare services, and whether or not the physician's behavior moderates the link of patient satisfaction and healthcare services. The main results of the regression analysis validate that healthcare services have a significant and positive effect on patient satisfaction. Specifically, the study suggests that the physician's behavior significantly moderates the effect of healthcare services on the satisfaction of patients. The overall opinions about the satisfaction level of patients for the availability of health services in the hospitals were good.**

Keywords: **patient satisfaction; healthcare services; physician's behavior; Takeo Province, Cambodia.**

I. INTRODUCTION

The growing concern about health and elevated economic levels of modern civilization have intensely improved the healthcare demands and shifted trends of the population towards attaining a healthier lifestyle [1]. As a result, the healthcare relationship has begun to stress on the superior healthcare service delivery due to the growing competition among hospitals. This delivery has persuaded the patients to make the best choice in selecting any hospital [2]. Improved patient care has become a priority for all healthcare service providers with the optimum objective of achieving a high degree of patient satisfaction [3]. At the same time, good healthcare service delivery, as compared to their counterparts, provides businesses or public trusts with the opportunity to distinguish their facilities in a competitive industry [4]. Currently, on account of the expanded expectations for ordinary services and higher customer's needs, it is obligatory for hospitals to give superior healthcare services to the patients and to fulfill their requirements [5]. In previous decades, healthcare services and their services are one of the rare topics in service studies in developing countries like Cambodia. While it has received extensive academic study, the need for improvement in healthcare services has grown which leads to challenges for the service provider and has become a complex task for scholars, government policymakers, therapeutic specialists and hospital administrators to fulfill the requirements of clients which help toward developing satisfaction. Satisfaction is one of the key factors pertaining to government policy or a successful business which can only be sustained through the delivery of exquisite service quality resulting in improved satisfaction. These ameliorated provisions require effective service delivery, cost allocation, and management strategies [6]. In the context of suppliers, there are two forms of service providers that are working particularly well in developing countries in both the private and public sector hospitals. Selecting the right health center and skilled physician is imperative to fulfill the aim of patient satisfaction as it suggestively influences the treatment of the patient [7].

II. LITERATURE REVIEW

Medical care is a complex social phenomenon serving several distinct functions, only some of which benefit health. The diversity of functions relates in part to the variety of problems presented to the medical care system by society. Medical care deals not only with problems of disease and injury, but also with problems of birth, death, and living-problems that are separated from disease or injury. In addition, medical care helps maintain the society in other ways, complementing the functions of schools, courts, law enforcement, and other systems concerned with the abilities of individual to conduct their lives in society [8]. Medical care serves the advancement of health through curing or preventing illness. However, curing and prevention are not the only purposes intended by the provider or sought by the patient. Other functions important to society, functions that may, in fact, be more important to the patient than those benefit health, are assessment of health status, separation of the ill from the well, and caring, which can also be described as helping to cope with illness. Implementing a person-centered approach to nursing and healthcare may provide a more therapeutic relationship between healthcare personnel, patients and their families underpinned by values of seeing patients as equal partners in planning, developing and assess healthcare [9].

III. HEALTHCARE SYSTEM IN CAMBODIA

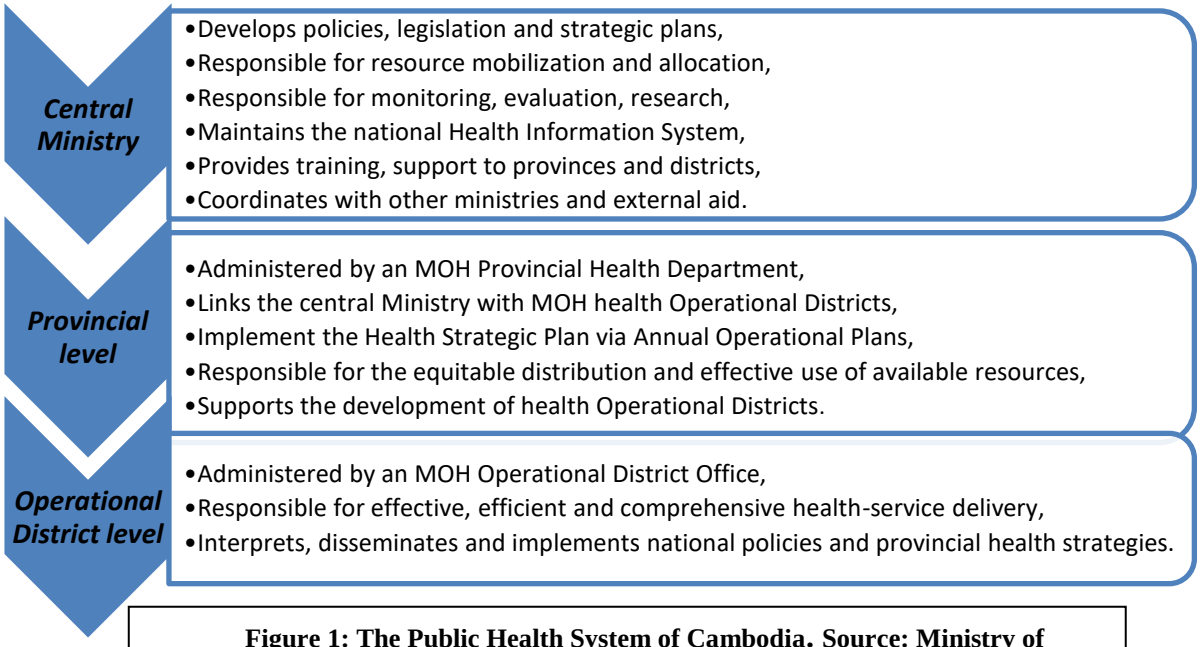

Figure 1: The Public Health System of Cambodia. Source: Ministry of

According to World Health Organization, the majority of Cambodian populations; around 80.5 percent are residing in rural area. However, as the mass development continues to be concentrated within urban economies, there is a broad gap between wealthy city dwellers and comparatively poorer population in the countryside. Cambodian population and healthcare system have struggled with many diseases in the Tropics, especially in rural areas. Cambodia faces challenges to ensure healthcare delivery to people in rural and remote areas because of the unequal distribution of doctors and increasing shortages of midwives. The need to ensure the sufficient staffing level with adequate professional profile and competencies, revision of the content of health professional, increase students' intake to school and university, and strengthening of measures to safeguard the quality of training and trainers to meet demand of people of Cambodia.

Cambodia has a pluralistic health system that the main health infrastructure and public healthcare are delivered through the Ministry of Health, while the other private sectors provides most outpatient curative care. Public health system in Cambodia is depending on district health system model and dividing into three different levels of responsibilities (Figure 1). Ministry of Health responsible for the delivery of government health service administers health programs at national level, provincial and health Operational District (OD) levels. The central MOH has three General Directorates that focuses on Health, Administration and Finance, and Inspection. These Directorates are responsible for ensuring the government's health objectives emphasized in the National Strategic Development Plan and the Cambodian Government's overall plan for national development called the Rectangular Strategy are translated into policies, strategies and guidelines in order to reach their targets. Health system can be understood as encompassing the supply of services to

target people based on six functions; service delivery, governance, financing, pharmaceutical management, information systems, and human resources [10]. The public health system of Cambodia divided into three basic levels of health infrastructure including provincial level hospitals, operational districts referral hospitals, and commune health centers; there is also smaller public health facilities called health post in some remote areas. Provincial hospitals are the highest level of public healthcare which available in each province. Provinces divided into several operational districts and a specific division to healthcare system. Each operational district has one district level referral hospital and 11 health centers in average.

IV. HEALTHCARE SERVICE AND PATIENT SATISFACTION

Best healthcare service deliveries empower hospital management to differentiate the hospital and upgrade proficiency and increase a practical competitive favorable position. Gronroos [11] characterized perceived quality as an assessment procedure, where the customer compares their expectations with their service observations. The quality of healthcare service is the disparity among customer perceptions and their assumptions regarding services. In the healthcare setting, the patients are the capital of the hospital. To satisfy and sustain customers, medical service delivery has turned out to be reasonably more imperative [12]. Patient satisfaction assists as a mode between behavioral intentions and the quality of healthcare service delivery.

❖ *Access to Healthcare*

Access to healthcare is an individual's ability to obtain appropriate healthcare services. Barrier to access can be financial (insufficient monetary resources), geographic (distance to providers), organizational (lack of available providers), and sociological (e.g discrimination or language barriers). Effort to improve access often focus on providing or improving health coverage [13].

Alike to many developing countries access to healthcare in Cambodia is constrained by poverty. Poor families cannot afford essential health services and resort to 'illegal' pharmacies, traditional healers and other unqualified private providers. It is estimated that about one-third of the population does not have the resources to pay for healthcare from either the public or private sector providers. The overall utilization of public health facilities is around 0.4 visits per person per year which according to the MOH is low and must be improved [14]. Access is also constrained by geographical location; particularly there are fewer health facilities and health workers in rural and remote areas than in urban areas. Approximately 54% of doctors are reportedly employed in Phnom Penh city, where only 9.3% of the population lives [15]. The government acknowledges these challenges and has expanded coverage and access, especially for the poor and other vulnerable groups, a key component of its health sector strategic plans [14]. Since the mid-1990s the government has been implementing a Health Coverage Plan which has sought to place health centers within a 10-kilometre radius or a maximum of two hours walk of the population and a referral hospital within 20–30 kilometers or a maximum of 3 hours by car or boat [14]. Health equity funds and community-based insurance schemes are designed to reduce or remove financial barriers to service access. Health equity funds have reportedly improved the use of public sector health facilities; although there are reports of many poor people still not using public facilities because they do not want to go far away from their homes [16]. There is a shortage of healthcare professionals in rural communities such as doctors, specialists, pharmacists, and nurses and it is very difficult to find a doctor in rural areas. People in rural do not have equal access to specialized care. People from rural areas are frustrated with their access to healthcare and some feel that there is an inequity in the quality of care that is provided in rural versus urban centers. Typical complaining about public health facilities in Cambodia are having to engage in costly and time consuming travel to reach each facilities (rather than seeking nearby or even receiving home care visits from private providers), personnel absence from public health facilities, long waiting time at facilities, frequent shortage of medicines, unpredictable costs and poor health worker attitudes toward patients [17,18].

❖ *Healthcare Quality*

What is healthcare quality? Customers, purchasers, and providers are the most affected group to answer this question. Consumers may expect quality in the delivery of healthcare service, patients need to get the right treatment and experience good outcomes, all of the people want to receive satisfactory interactions with care givers, while consumers want physical facilities where care is provided to be clean and pleasant, and they want doctors to use and supply the best available technologies. Consumer expectations are the only part of the definition; however, purchasers and providers may view quality in term of other attributions.

The resource structures are person-related qualities that refer to the caregivers, and physical and administrative environmental qualities that in turn refer to infrastructural components of the care environment, such as organizational rules and technical equipment. The patients' preferences consist of a rational aspect that refers to the patient's strive for order, predictability and calculability in life, and a human aspect that refers to the patient's expectations that her/his unique situation is taken into account. The patients' perception of quality of care based on this theoretical model may be considered from four dimensions: the medical-technical competence of the caregivers, the identity oriented approach of the caregivers, the physical-technical conditions of the care organization, and the socio-cultural atmosphere of the care organization (Figure 2) [19].

Most Cambodians do not have access to quality health services which underlines the importance of focusing on aspects of availability, affordability, and acceptability of facilities, goods and services. Quality of care and discriminatory attitudes, irrespective of the type of provider are frequently reported to vary depending on the patient's ability to pay. Waiting times tended to be longer or less attention to be given when the patient is deemed to have a low ability to pay. Still, in some cases there is a difference in how people were treated. Few community health workers are found to diagnose conditions accurately and provide referrals to appropriate services. Ozawa & Walker (2011) [20] have shown that the popular view of quality of care by public and private providers in Cambodia relates to waiting time, perceived costs, effectiveness and availability of medicine, mode of administering medicines and interpersonal skills displayed by medical personnel.

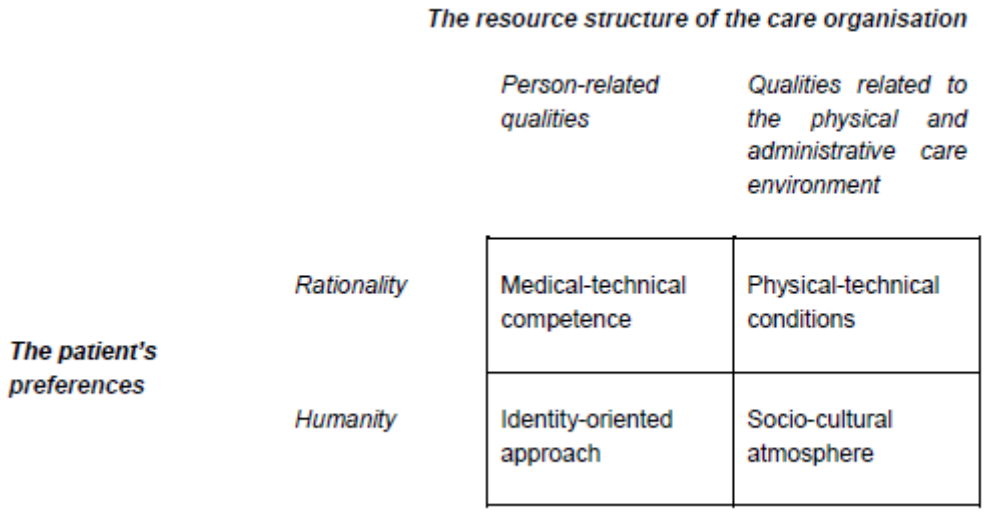

Figure 2: Theoretical model of quality of care from the patients 'perspective (Wild, et al., 1993).

V. RESEARCH METHODOLOGY

This study is designed as a cross sectional and quantitative study conducted in Takeo referral hospital situated in the southern part of Cambodia. The standardized questionnaire is used to randomly survey 450 people. The questionnaire aim to gather the background information, knowledge, attitude, and practices related to healthcare service of the respondents. The detailed interviews are hold with the referral hospital staffs and relevant informants. The majority of patients are a mixed occupational background individual as farmers, traders, service class and students avail the super-specialty healthcare facility.

VI. RESULT

A total of 450 patients attending the various departments were included in the study. The mean age of the respondents were 39 years. Among those, 66.4% of the study population was males. Over 87% of the respondents were more than 30 years old. Majority of the respondents (58.9%) were the people in rural areas. 53.55% were employed while the rest were students, housewives, or were retired. Most of the respondents (44%) were illiterate. Most of the respondents (87.2%) were married. A good number of respondents belonged to the lower socioeconomic status. (Table-1) Related to the availability of doctors, 62% of the respondents attending OPDs did not report any problem related to it but 76% of them were dissatisfied with timings of the hospital as OPD was open only from 9 AM in the morning and 2 PM at the evening.

Out of total, 46% reported that only junior doctors were available in the emergency department which is only option available to the patient for half of the day and whole of the night. The level of satisfaction related to availability of doctors was lower (46%) in admitted patient.

Table 1: Socio-demographic profile of the respondents (n=450

Characteristics	*Male, No. (%)*	*Female, No. (%)*	*Total, No. (%)*
Age Groups			
< 20 Years	16 (5.5)	6 (3.77)	22(4.88)
20-29 Years	26 (8.9)	2 (1.25)	28(6.22)
30-39 Years	73 (25.8)	65(40.88)	138(30.66)
30-49 Years	94 (32.3)	72(45.28)	166(36.88)
> 50 Years	82 (28.2)	14(8.80)	96(21.33)
Place of Residence			
Rural	167(57.4)	117(73.28)	284(63.11)
Urban	124(42.6)	42(26.41)	166(25.77)
Education			
Illiterate	106(36.4)	92(57.86)	198(44)
Primary	72(24.7)	58(36.4)	131(29.11)
Secondary	95(32.6)	8(5.03)	103(22.88)
Graduate	17(5.8)	1(0.62)	18(4.0)
Occupation			
Working-class	217(74.57)	24(15.09)	198(44)
Student	30(10.30)	14(8.80)	131(29.11)
Housewife	0(0)	113(71.06)	103(22.88)
Retired	50(17.1)	2(1.25)	18(4.0)
Socio-Economic Status			
Class I	28(9.62)	32(20.01)	60(13.33)
Class II	32(10.99)	18(11.0)	50(11.1)
Class III	55(18.90)	48(30.01)	103(22.8)
Class IV	112(38.48)	35(22.01)	147(32.66)
Class V	64(21.99)	26(16.35)	90(20)

In accordance to the practices of all health facilities, people coming to hospital registered and waited for their turn for consultation. The proportion of respondents showed that waiting time was excellent, very good and good were 18%, 32% and 20% respectively. Most patients had to wait for 15-30 minute to be called into the consultation room. 32.4% of the patients said that they did not have to wait, but were called instantly. Related to the satisfaction with the attitude of healthcare providers they were asked to indicate if the physician/doctors were courteous, listened to their complains, took enough time and explained what they wanted to know and gave them good advice and treatment. In this view of care 66.8% of respondents were satisfied with doctors (outdoor-86.6% and indoor-46.8% respectively) whereas 33.2% were dissatisfied (more in indoor respondents -53.5%). (Table-2) Regarding to the attitude and behavior of other staff members, it was seen that 50%, 59%, 60% and 45% were satisfied regarding behavior of registration clerk, supporting staff, pharmacist and nurses. More (55%) of patients were dissatisfied with behavior of nurses than any other healthcare staff. Still, for further information on the behavior pattern regression analysis was done to compute the effect of behavior of each of the healthcare provider on the overall satisfaction grading by the respondents. The association between the relationship with other healthcare providers and overall client satisfaction also yielded statistically significant results. (Table-2)

Related to the infrastructure and basic facilities at the hospital, the overall adequacy of these facilities was 71.7%. Most of the respondents (97.4%) were satisfied with parking facilities while 32.5% complained that water coolers were not working and areas where drinking water facility was available were not clean.

Table 2: Patients satisfaction with the attitude and behavior of the healthcare providers (n=450)

Aspect of Care	*Satisfied*			*Dissatisfied*			
	Outdoor (n=315)	Indoor (n=135)	Total (n=450)	Outdoor (n=315)	Indoor (n=135)	Total (n=450)	#p-value
Behavior of the registration clerk	51	49	50	49	51	50	0.001
Behavior of supporting staff	68	50	59	32	50	41	0.003
behavior of the pharmacist	60	59	60	40	41	40	0.06
behavior of nurse	52	38	45	48	62	55	0.036
behavior of doctor	86.8	46.8	66.8	13.2	53.2	33.2	0.000

Asking about availability of other parameters such as lighting, fans, seating facility and general cleanliness, it was seen that the level of satisfaction varied in respect to the services obtained (92%, 78.5%, 86.5%, 94% and 74.5% respectively). 84% of the participants identified accessibility to the hospital as the commonest problem. 45% had to walk for 1-2 kms or wait for half an hour to one hour for getting any mode of transport to reach the hospital. 68% were of the opinion that the road connecting hospital to highway was also not properly maintained.

Out of the total respondents 35.5% were of view that hospital toilets were not clean and 18.25% felt food and canteen facilities required upliftment. 16% respondents found it difficult to find the way to various departments showing the lack of signboards in the hospital building. Overall, the study showed that 28.1% individuals were dissatisfied with availability of basic amenities in the hospital. (Table-3) The degree of satisfaction and dissatisfaction at the various service windows (Table-4).

Table 3: Availability of General basic facilities in the hospital (n=450)

Availability of Facilities	*Adequate (%)*			*Inadequate (%)*		
	Outdoor (n=315)	*Indoor (n=135)*	*Total (n=450)*	*Outdoor (n=315)*	*Indoor (n=135)*	*Total (n=450)*
Toilets	70	59	64.5	30	41	35.5
Drinking water	74	61	67.5	26	39	32.5
cleanliness	80	69	74.5	20	31	25.3
Canteen/Food facilities	87	76	81.45	13	24	18.5
Lighting arrangement	96	88	92	4	12	8
Waiting room/seating availability	91.5	81.5	86.5	8.5	18.5	13.5
Fans	83	74	78.5	17	26	21.5
Parking	97.3	97	97.4	2.7	3	2.8
Signboards/locating departments	89	79	84	11	21	16
Overall Rating	78	65.5	71.7	22	28.3	25.1

Most of the respondents (73.85%) were satisfied with pharmacy. As far as availability and quality of drugs was concerned the respondents showed a higher level of satisfaction (72%) in contrast to the cost of drugs which showed a relatively higher level of dissatisfaction (43.3%). 20.04% of the patients complained about services obtained from the Radiology Department. They were of the opinion that though hospital had most of the advanced equipment in the department but many of those were either not working or the technicians were not available to operate them.

The most frequently complaint (36.1%) included cost for the radiological investigations done in the department followed by prolonged waiting time (24.4%). Microbiological and Pathological laboratory services were somewhat satisfactory as only 15.77% were not satisfied with service level. But most of the patients were unsatisfied with biochemistry laboratory services as facilities for advanced biochemical investigations were not available in the department. 46% were referred to other private facilities for investigations. 29.11% reported problem with timely delivery of investigation reports, while another 22% had complaint regarding the expenses occurred for the pathological and biochemical laboratory investigations. On assessing the dissatisfaction regarding missing of reports only 4.44% and 9% had reported the problem from laboratory and radiology department respectively. Overall dissatisfaction level in relation to record keeping was reported to a level of 5.5%.

Table 4: Degree of satisfaction at various service windows (n=450)

Degree of Satisfaction	*Satisfied*		*Dissatisfied*	
	No.	*% age*	*No.*	*% age*
Pharmacy Store				
Availability of essential drugs	418	92.8	32	7.11
Quality of drugs	324	72	126	28
Cost	255	56.6	195	43.3
Total	997	73.85	353	26.14
Radiology / USG				
Prompt delivery of services	340	75.6	110	24.4
Technically trained staff	421	93.6	29	6.4
Cost	288	64	162	36.1
Delayed reports	340	75.6	110	24.4
Missing reports	410	91	40	9
Total	1799	79.9	451	20.04
Laboratory				
Prompt delivery of services	419	93.11	31	6.88
Technically trained staff	376	83.55	74	16.44
Cost	351	78	99	22
Delayed reports	319	70.88	131	29.11
Missing reports	430	95.55	20	4.44
Total	1895	84.22	355	15.77
Health Records				
Properly placed	430	95.5	20	4.44
Missing folders	420	93.33	30	6.66
Total	850	94.4	50	5.55

It showed that 80.9%, 79.3%, 70.9% and 56.8% of the respondents were satisfied with information and support, organization of care, availability of general basic facilities and doctor-patient relationship. However, there was high level of dissatisfaction (84%) as far as accessibility of healthcare services was concerned. To assess the overall satisfaction, it showed a high proportion of respondents (79.1%) were satisfied with the healthcare services received from the hospital while only 20.9% were dissatisfied. The overall satisfaction level was higher (86%) in patients attending outdoor than indoor patients (73%). Level of satisfaction was significantly associated with background (p=.0032), level of education (p=.023) and socioeconomic status (p=.016) of the participants. Level of satisfaction was significantly higher in respondents who were illiterate, from low socioeconomic status and rural background.

The results of the study show that most of the respondents interviewed were satisfied with the services they received. Very few similar studies have been done and therefore we lack the data for comparison. Yet, the findings of the survey are quite helpful if they are transformed into actions for improving the quality of healthcare. However, the high satisfaction must be put into the context of referral hospital, which receives patients who have often being shunted around between lower health facilities and attended by auxiliaries and general practitioners. Measuring patient satisfaction has many purposes, but there are three prominent reasons to do so. Such interviews help to evaluate healthcare services from the patient's point of view, facilitate the identification of problem areas and help generate ideas towards resolving these problems. Despite a pretty good level of patient satisfaction, a small, but by no means insignificant, proportion of patients expressed dissatisfaction. The fact that patients expressed dissatisfaction with the services indicates that hospital administration needs to do more in the drive towards improving services.

The satisfaction regarding listening of complaints and behavior of doctor and paramedical staff was around 60%. The dis-satisfied percentage had different view of doctors and healthcare providers. 80% of them felt that doctors have no time to discuss with patients or listen to them patiently. The fact for this dissatisfaction could be attributed to the increasing loads of the patients. The present study found 35.5% of the respondents were dissatisfied by the toilet facilities in the hospital building. A high proportion of patients were dissatisfied with accessibility of the hospital. This is in concordance with findings from other studies where fewer patients were satisfied with ease of accessing care. In the current study it was

seen that 66.8%, 50.0%, 59%, 60% and 45% were satisfied regarding behavior of the doctor, registration clerk, supporting staff, pharmacist and nurses. The study shows a high level of dissatisfaction (18.25%) regarding canteen/food facilities. This could be explainable by the fact that increasing modern era demands and awareness of the healthcare seekers push the medical care providers to deliver quality medical care in package with quality hospitality and related facilities to solace them.

Table 5: Patient's satisfaction to healthcare services (n=450)

Patient Overall Rating					
Aspect of Care	***Excellent***	***Very Good***	***Good***	***Fair***	***Poor***
Doctor-patient relationship	29.1	22.2	5.5	29.1	14.1
Available of general basic facilities	33.3	26.8	10.8	17.6	11.5
Information and support	44.6	25.3	11	13.3	5.8
Accessibility and healthcare service	7.2	3.9	4.9	55.5	28.5
Organization of Care	30.5	27.8	21	15.7	5
Overall satisfaction	**35.8**	**26.3**	**17**	**14.3**	**6.6**

VII. CONCLUSION

Overall, the study showed a moderate level of satisfaction of patients with services obtained from this referral hospital. We have discovered a number of potential barriers and facilitators that may influence in patient satisfaction in the studied area. Accessibility could be improved by running buses on paid basis. Cleanliness should be given top priority and areas with drinking water facility should be specifically maintained properly. Certain improvements are also needed in the waiting area by making it informative and comfortable Hospital administration should ensure that all the equipment is working properly and well maintained. The fact that some patients expressed dissatisfaction with the services indicates that healthcare providers need to do more in the drive towards improving service windows in order to improve efficiency, minimize patient waiting times and provide for patient comfort. Periodic patient satisfaction survey should be institutionalized to provide feedback for continuous quality improvement.

REFERENCES

[1] Li, M.; Lowrie, D.B.; Huang, C.-Y.; Lu, X.-C.; Zhu, Y.-C.; Wu, X.-H.; Shayiti, M.; Tan, Q.-Z.; Yang, H.-L.; Chen, S.-Y. Evaluating patients' perception of service quality at hospitals in nine Chinese cities by use of the ServQual scale. Asian Pac. J. Trop. Biomed. 2015, 5, 497–504.

[2] Bleustein, C.; Rothschild, D.B.; Valen, A.; Valatis, E.; Schweitzer, L.; Jones, R. Wait times, patient satisfaction scores, and the perception of care. Am. J. Manag. Care 2014, 20, 393–400. [PubMed] 3. Lee, M.A.; Yom, Y.-H. A comparative study of patients' and nurses' perceptions of the quality of nursing services, satisfaction and intent to revisit the hospital: A questionnaire survey. Int. J. Nurs. Stud. 2007, 44, 545–555.

[3] Int. J. Environ. Res. Public Health 2019, 16, 3318 13 of 16

[4] Karatepe,O.M.;Yavas,U.;Babakus,E.Measuringservicequalityofbanks: Scaledevelopmentandvalidation. J. Retail. Consum. Serv. 2005, 12, 373–383.

[5] Zarei, E.; Daneshkohan, A.; Pouragha, B.; Marzban, S.; Arab, M. An empirical study of the impact of service quality on patient satisfaction in private hospitals, Iran. Glob. J. Health Sci. 2015, 7.

[6] Sun, J.; Hu, G.; Ma, J.; Chen, Y.; Wu, L.; Liu, Q.; Hu, J.; Livoti, C.; Jiang, Y.; Liu, Y. Consumer satisfaction with tertiary healthcare in China: Findings from the 2015 China National Patient Survey. Int. J. Qual. Health Care 2017, 29, 213–221.

[7] Shabbir, A.; Malik, S.A.; Malik, S.A. Measuring patients' healthcare service quality perceptions, satisfaction, and loyalty in public and private sector hospitals in Pakistan. Int. J. Qual. Reliab. Manag. 2016, 33, 538–557.

[8] Parsons, T.: The social system. Free Press, New York, 1951, pp. 428-479.

[9] McCormack, B., Dewing, J. & McCance, T. (2011). Developing person- centred care: Addressing contextual challenges through practice development. Online Journal of Issues in Nursing, 16(2).

[10] Gilson, L. (2012). What is health policy and systems research? In L. Gilson (Ed.), Health Policy and Systems Research: A Methodology Reader. Retrieved from http:// www.who.int/ alliancehpsr/alliancehpsr_reader.pdf

[11] Grönroos,C.Aservicequalitymodelanditsmarketingimplications. Eur. J.Mark. 1984,18,36–44.

[12] Arasli, H.; Haktan Ekiz, E.; Turan Katircioglu, S. Gearing service quality into public and private hospitals in small islands: Empirical evidence from Cyprus. Int. J. Health Care Qual. Assur. 2008, 21, 8–23.

[13] Glossary of Terms Commonly Used in HealthCare, 2004 Edition, Academy Health, www.academyhealth.org

[14] government of Cambodia 2008, Health Strategic Plan: 2008–2015 – Accountability, Efficiency, Quality, Equity, Ministry of Health, Phnom Penh.

[15] Chhea C, Warren, N and Manderson, L 2010, 'Health worker effectiveness and retention in rural Cambodia', Rural and Remote Health, vol. 10.

[16] Asante, A 2009, Interview with Cambodia Ministry of Health official, personal communication, 11 November 2009.

[17] Collins, W. (2000). Medical Practitioners and Traditional Healers: A Study of Health Seeking Behavior in Kampong Chhnang, Cambodia. Phnom Penh, Cambodia, Center for Advanced Study.

[18] Annear, P. L., D. Wilkinson, et al. (2006). Study of Financial Access to Health Services for the Poor in Cambodia. Phnom Penh, Cambodia Ministry of Health, WHO, AugAID, RMIT University.

[19] Wilde, B., Starrin, B., Larsson, G. & Larsson, M. (1993). Quality of care from a patient perspective: A grounded theory study. Scandinavian Journal of Caring Sciences, 7(2), 113-120.

[20] Ozawa S, Walker D (2011). Comparison of trust in public vs private health care providers in rural Cambodia. Health Policy Plan.26:i20–i29. doi:10.1093/heapol/czr045.