Comparing Private and Public health care provision: an explorative approach to citizens from Spain and Italy

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Abstract

The main objective of this study is to compare users´ perception and evaluation of both public and private healthcare service, distinguishing between primary and specialty care, with a cross-cultural approach on two Mediterranean countries: Italy and Spain.

Within an exploratory approach and following a descriptive aim, we have conducted a quantitative methodology: after a literature review about health marketing and health management, we have developed a questionnaire and collected end-users´ perceptions in both countries.

Our of the results, implications for scholars interested in marketing of public services are proposed in terms of the idiosyncrasy of health consumer behaviour: satisfaction with and willingness to recommend a service provider (public or private) according to comparative service provision (primary or specialized care service), and geographical context (Italy and Spain). Implications for health managers highlight the relevance of time management, experiential marketing in health service provision, word-of-mouth relevance and behavioural intentions.

Keywords

Healthcare service, end-users, primary and specialized, cross cultural, Italy, Spain

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1 Introduction

Health provision accounts for a plethora of services and goods, which include mostly immaterial components that the patient cannot see while experiencing the service (Altuntas, Dereli, & Yilmaz, 2012). In other words, they are mostly credence qualities. A patient's satisfaction with health services depends on his/her individual preferences, personality and experience, but also on personal experiences felt during the illness (Fotiadis and Vassiliadis, 2013) Further, according with the marketing literature (Oliver, 1997; Yu and Dean, 2001; Thom et al.,, 2004), it could be argued that patient satisfaction is not merely influenced by the technical aspect of the health services itself (which is obviously one of the most important factor), but also by the emotional, cognitive, and social values associated with them. Then it could be argued that emotions can supplement attitudinal judgments for behavioural predictions (Allen et al., 1992)

In the framework of the traditional polarization between public and private healthcare, taking into account the greater relevance that health management models are gaining (Christensen et al., 2007; Herzlinger, 2007; PWC Health Research Institute, 2010), this study aims at comparing the users´ perception and evaluation of both public and private healthcare, distinguishing between primary and specialty care, with a cross-cultural aim: conducted in two different countries, Italy and Spain, it allows comparisons between the two systems.

Public healthcare services are now in Mediterranean economies in the eye of the storm. They are deeply complex and dynamic services, being at the same time, highly relevant to the consumer. From this especial idiosyncrasy, with an increasingly informed and demanding patient (Errasti, 1997; Caviedes, 2009), we aim at exploring patients perceptions of different types of management (public or private), different services provided (primary or specialized), and make describe them in two different counties (Spain and Italy).

The paper is organized as follows. First, we highlight different aspects shaping the multidimensional healthcare service such as: the waiting lists; their experienced sensations; word-of-mouth relevance; and their behavioural intentions in the future. Second, we raise a distinction between primary (paediatrician, general assistance,…) and specialized (surgery, hospital,…), which remains important for assessing the peculiarity of the healthcare system (Varela, 2003; Rial, & García, 2003). Third, we aim at exploring two different environments and realities: the Italian and the Spanish health system. So, through a quantitative survey, we try to shed light on the comparison of the users´ perceptions of health services on public and private models of healthcare management, made in two different countries.

2 Conceptual framework

The current economic and confidence crisis in the markets have overshadowed health systems sustainability in Europe. Therefore, there is some concern about public health systems viability and their coexistence with private systems, trying to live together in a proper relationship.

In this situation, considering three stakeholders in health services provision (government, providers and population), the former represents the fundamental element of the activity because their opinions are indispensable to decision making. Besides, it is important to understand the changing role that patients have developed becoming more demanding and more informed. Given these considerations, we should take into account broadly the users/patients role as key participants in health management activities.

2.1 Health management in Spain

The Spanish National Health System, like Italian, is inspired by the 1942 Beveridge report whose characteristics are: universal coverage through tax funding, management and control by government, state ownership of the means of production, public provision, salaried physicians, and co-payments by patients. This system was adopted by Denmark, Finland, Ireland, Norway, Sweden and United Kingdom after World War II. Later, Spain, Italy, Greece and Portugal introduced it in the 1980s (Errasti, 1997). It is important to highlight the fact that both Spain and Italy share the same Beveridge system since a similar period of time. It will be appreciated in order to allow comparisons.

By contrast, other European countries such as Austria, Belgium, France, Germany, and the Netherlands chose Bismarck system, the Social Security system, characterized by: mandatory universal coverage under Social Security; funding contributions employers and employees; public and private ownership of the means of production; and public and private provision of healthcare.

Spanish National Health System, compared to other countries, is highly decentralized (Pérez Somalo, 2008, Jimenez et al., 2008). Health management in Spain is transferred to the Autonomous Communities, being harmonized through the Spanish Inter-territorial Council of Health that seeks to give cohesion to the system and ensure the rights of citizens throughout. Each health counselling is responsible for defining its own health boundaries: departments and, at a lower level, areas. All of them are defined taking into account geographical, socio-economic, demographic, occupational, epidemiological, cultural, climatic characteristics and the existence of means of transport and communication.

This organizational structure distinguishes between primary care -provided in health centres and clinics-, and specialty care -whose performance takes place in hospitals and specialty centers-. This fact makes difficult an integrated overall care (Gómez Moreno et al., 1997), so we find in the literature authors who see as a challenge to be achieve coordination between both primary and specialty care (Ortún, 1998b; Alfaro et al., 2002, Ojeda et al., 2006).

The Spanish National Health System has traditionally enjoyed a great social recognition. It is amongst the more valued social institutions. And health barometers indicate that, despite most people believe some changes are needed, its performance is considered as acceptable and its professionals deserve high confidence (Artells and Herrero, 2013).

Despite this assessment, some pockets of inefficiency have been identified which, together with the economic situation, have come to question the sustainability of public health system. Among others, we find the following: under-funding of the health

system; excessive drug costs; technological overuse; politicized management; shortage of beds of medium and long stay, geriatric care; marginalization of primary care; progressive privatization of health provision; lack of planning (Federation of Associations for the Defence of Public Health, 2011).

Beyond this situation, Spain enjoys a public and a private health system that live together (McKee et al., 2006). In spite of having guaranteed healthcare through the public system, some people pay additionally for purchasing private health (Triadó, 2002). Selecting a private provider has sense in those people without public coverage. However, in most cases it is not so: they are voluntary buyers, with full power of choice, that benefit from both systems.

Thus, private healthcare is relegated to the role of reinsurance, with alternative and complementary functions of public healthcare: substitute because it covers what is already covered by the National Health System; supplementary because it offers a more complete service including services not covered by the public one; and supplemental because they allow faster service and increase the capacity of consumer choice (Barr, 1992).

In this context, with a dominant public health system and a private health system that is playing a secondary role, it makes sense to conduct a study as ours, which seeks to compare useers perceptions of both systems.

2.2 Health management in Italy

In the last four decades, Italian health system has been experiencing relevant changes as a consequence of the so-called “three health reforms” namely: 1978, 1992 and 1999 (Di Gregorio, 2008). Healthcare is provided to all citizens and residents who receive services from ASL (Aziende Sanitarie Locali) and AO (Aziende Ospedaliere) by a mixed public-private provision. The public part is the national health service (Servizio Sanitario Nazional referred as SSN), which is organized under the Ministry of Health and it's administered on a regional basis. The SSN deliver health services through the aforementioned ASL and AO. The SSN is financed through the National fiscal tax system, the tickets that the Italian citizens have to pay to ASL (based on their income), in order to contribute to the payment of the services they receive and, as well, the money people pay out-of-pocket to receive health services from the “free market” provided by both public and private hospitals (Pammolli and Salerno, 2009, 2010). Thus the main difference with the Spanish health system refers to the tickets that the Italian citizens have to pay to ASL (based on their income). In Italy, family doctors are entirely paid by the SSN and have a limit of 1500 patients. Visits by specialist doctors or diagnostic tests are provided by the public hospitals or by conventioneer private ones. Patients just ought to co-pay for them if they are prescribed by the family doctor. The Italian system gives patients the possibility to choose the "free market" option, provided by both public and private hospitals. In this case a patient pays completely out-of-pocket, and has generally much shorter waiting times. Finally, surgeries and hospitalization provided by the public hospitals or by conventioneer private ones are completely free of charge for everyone, regardless of the income.

3 Method

According to this previous review, we posted the aforementioned aim of this paper, by conducting two separate surveys performed in Italy and in Spain, with the same questionnaire. The main idea is to collect and analyse by citizens in both countries who assess their perception of public and private healthcare, in levels of primary and specialty care.

3.1 Questionnaire design

An ad-hoc questionnaire was built using a three-stage methodology. First, we gathered qualitative information through three focus groups of patients with different profiles to explore the way they evaluate and perceive health services. Secondly, we conducted three focus group with Italian doctor and health managers, in order to gather more information on the side of the service providers. From the statements proposed in the focus groups, information was collected to draft items to be used in the questionnaire. Finally, the information was completed with an additional literature review related to service quality in healthcare systems (e.g: Babakus and Mangold, 1992; Headley and Miller, 1993; Youssef, Nel, and Bovaird, 1995; Lam, 1997; Lim and Tang, 2000; Wisniewski and Wisniewski, 2005; Lin et al., 2009; Fotiadis and Vassiliadis, 2013). Upon similarities in these studies, several scales on service quality were agreed, and emotions were measured using items taken from Paul (2009), Russel (1980), Bigné and Andreu (2004) and Del Chiappa et. al. (2013). Finally, loyalty, as a multidimensional construct, was measured with two dimensions, namely Word of Mouth (WOM) or positive recommendation and intention to return (Zeithaml et al. 1996).

The areas selected for the questionnaire were both public and private healthcare with the same questions in order to allow comparisons, distinguishing between primary and specialty care. It is important to note that the first question was the type of healthcare provider they attended in the last 2 years (public, private or both of them) to better distinguish users and make comparisons.

Related to Spain, we adapted this Italian questionnaire to the Spanish health system specificity (avoiding mentioning health tickets that do not exist). We pretested upon a sample of 20 students, it in order to identify gaps in research objectives. And, after rewording some sentences, we developed a revised questionnaire. Once drafted and finalized the questionnaire, we proceeded with the selection of the sample as explained below.

3.2 Sample

First, in Italy the sample obtained was of 700 users/patients. Data were collected in the Region of Sardinia and thus are not representing Italy as whole. Sample profile was: 44% male and 56% female; the majority (65%) had higher education or College; and most of them (68%) were workers or retired people.

Regarding to the Spanish sample, the collected sample was 103 users/patients from the region of Valencia. Sample profile was similar to Italian: 28% male and 72% female; the majority (55%) had higher education or College; and most of them (70%) were workers or retired people.

Taking into account this quantitative analysis, we propose then a three-dimensional approach (2*2*2): 2 systems—public and private---; 2 healthcare services ---primary and specialized--- and 2 countries ---Italy and Spain---. Within this approach, a descriptive analysis is performed, allowing us to identify differences between the public and private health service, both in primary and specialized care in both countries.

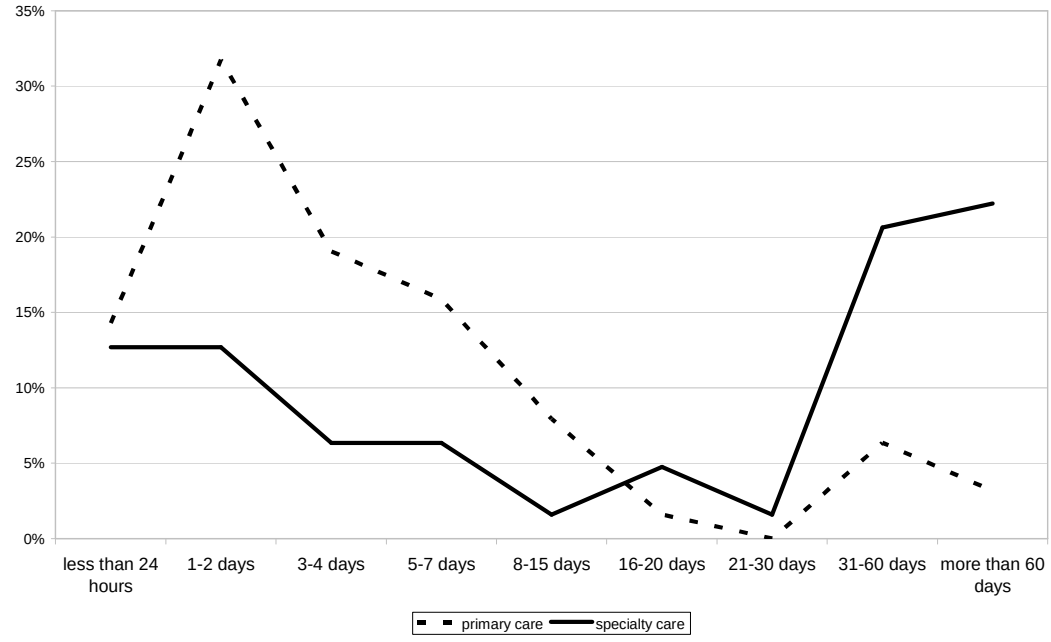
4 Results

According to the conceptual framework and the methodology, we show patient perceptions and evaluations about: waiting times, experienced sensations, word-of-mouth relevance, and behavioural intentions.

4.1 Waiting times

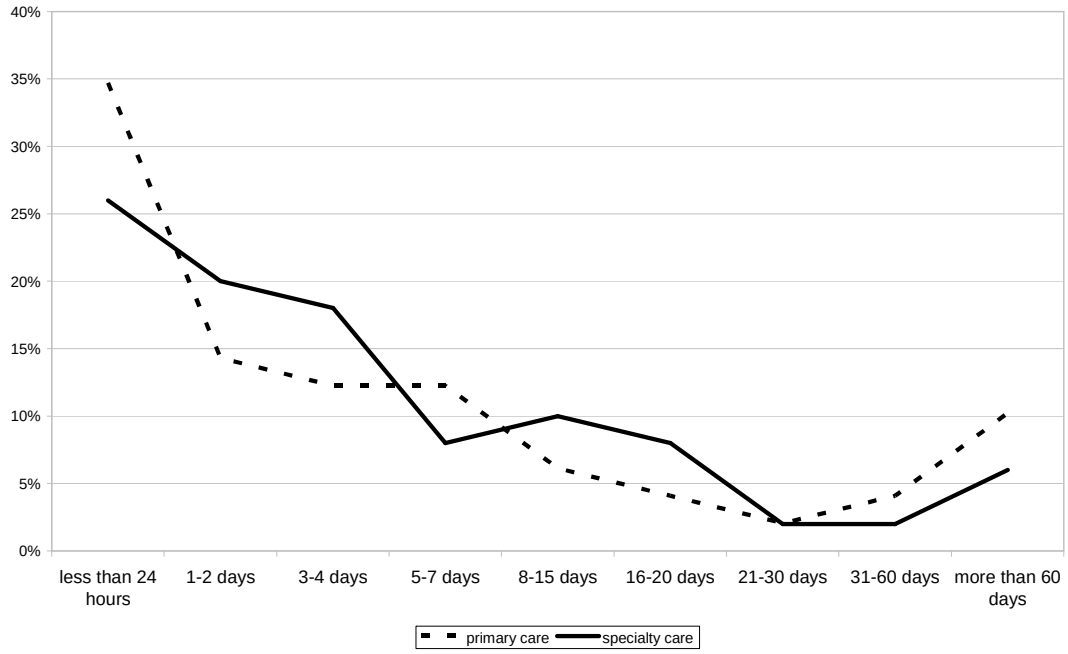
Speed is one of the most valued factors for the patient in order to select one or another type of health (Bateson, 1995, Van Looy, 1998). In the health service, the patient is faced with different waiting times such as the ease of getting an appointment, the wait to get in the office or the delay in emergencies. Because of that, waiting times have become a public healthcare problem. So, patients were asked about their waiting times perception, and more specifically, about the time they usually wait. Their answers are shown in Figures 1 to 4.

Figure 1: Spain – Waiting times – Public healthcare



Source: Own elaboration

Figure 2: Spain – Waiting times – Private healthcare

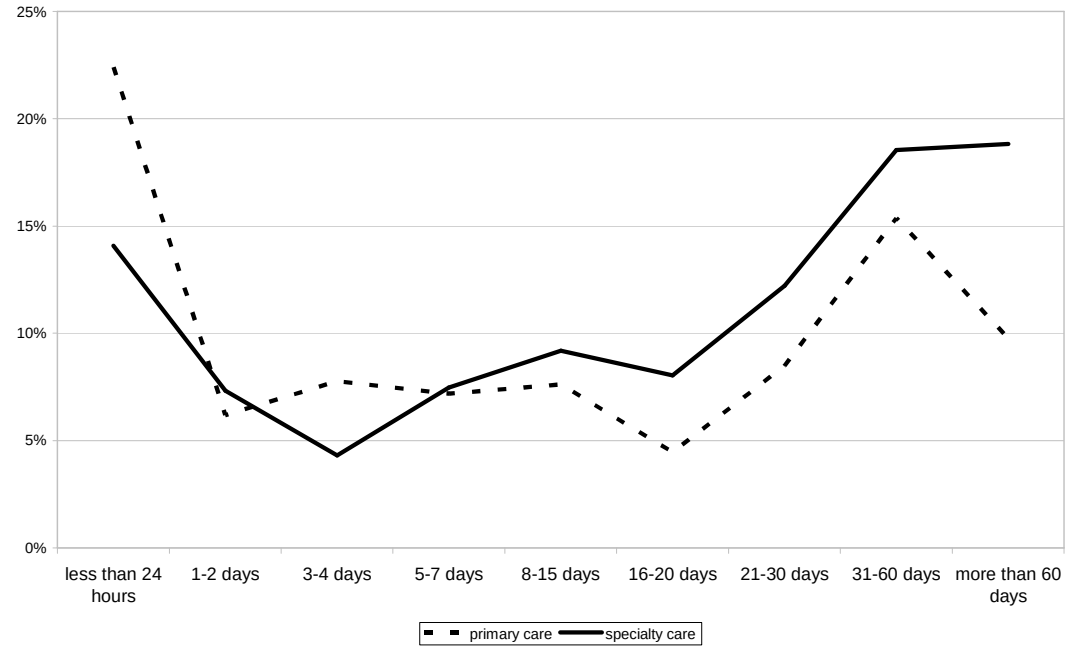


Source: Own elaboration

Spanish results are shown in Figures 1 and 2 with primary care in dotted line and specialty care in continuum. According to these figures, it seems that waiting time in Spanish public service is different depending on the type of care. While primary care occurs in 1-2 days, hospital care shows expected peaks of 21-60 days. Instead, waiting times at the private service show a decreasing trend (meaning less waiting times) in both primary and hospital care.

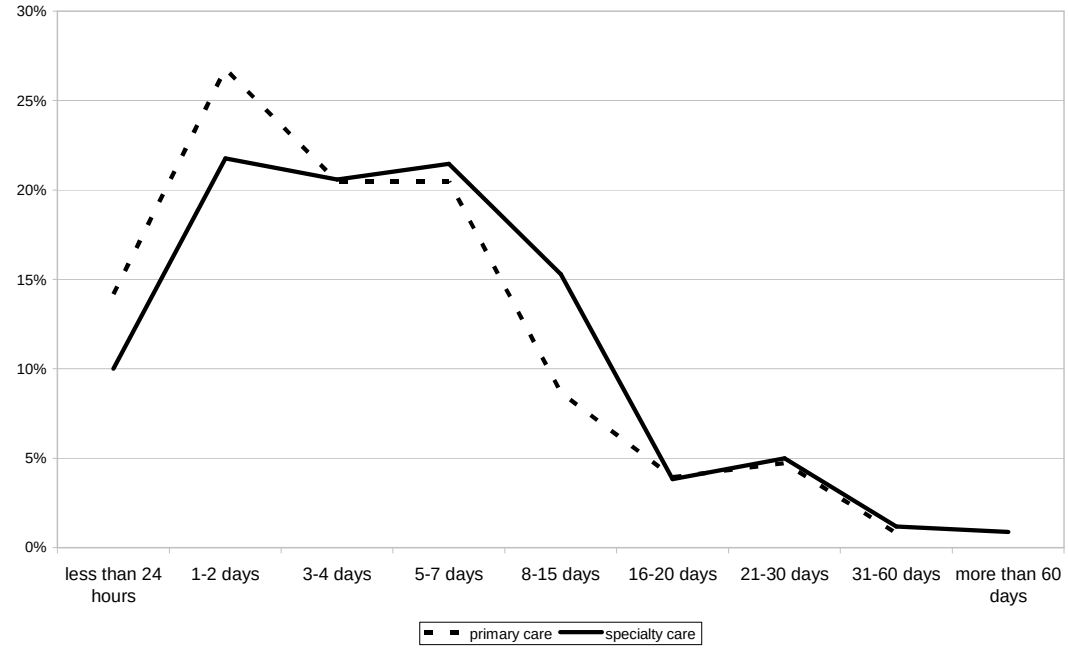
Italian results are shown in Figures 3 and 4 with primary care in dotted line and specialty care in continuum. As we can see, the situation is similar than in Spain with less waiting time in private than in public healthcare. Related to primary and specialty care, results are similar too in both countries.

Figure 3: Italy – Waiting times – Public healthcare



Source: Own elaboration

Figure 4: Italy – Waiting times – Private healthcare



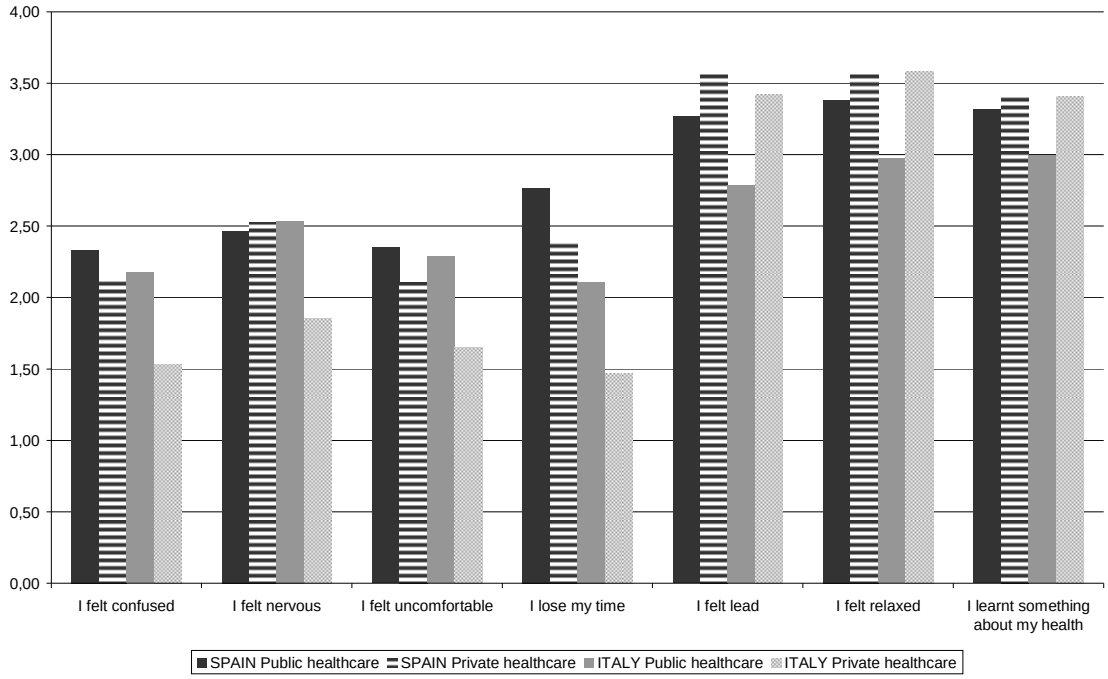
Source: Own elaboration

Consequently, we can say that, according to our results, both countries show similar results: both of them show less waiting time in private than in public healthcare.

4.2 Experienced sensations and emotions

From an experiential approach, it can be considered that fat the time of consumption; customer's experience will determine satisfaction (Schmitt, 1999). When a consumer purchases a service, he/she is buying an experience, basically emotional, created with the delivery of that service (Bateson, 1995). In line with this approach, patients were asked for the sensations perceived at the time of service consumption. Once more, we distinguish between public and private service in both countries.

Figure 5: Spain *vs.* Italy – Experienced sensations – Public *vs.* private healthcare



Source: Own elaboration

According to this figure, most patients feel lead and relaxed, being few who have felt confused or nervous. Experienced sensations are better in private than in public healthcare in both countries. Spanish patients feel more lead and relaxed and learn more about their health than Italian. However, Italian patients feel less confused, nervous, and uncomfortable and feel in a less level that they have lost their time.

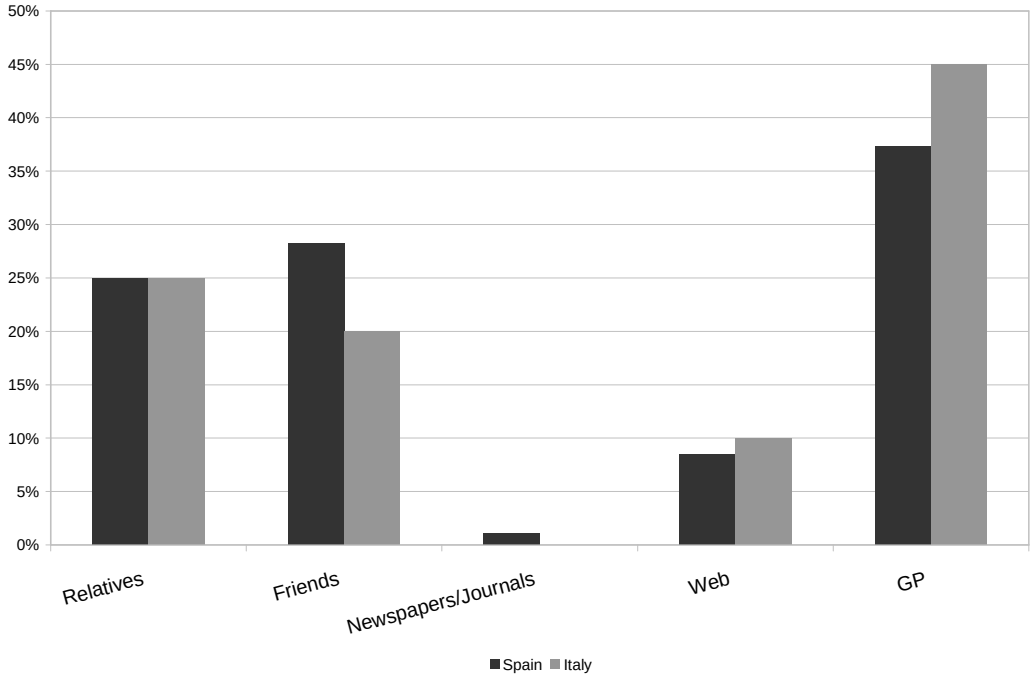
4.3 Word-of-mouth

Satisfied customers may transfer this feeling to others by recommending the service: this behaviour is called word-of-mouth. This fact contributes to promote a better image and company reputation (Robinson and Etherington, 2006, Ferguson et al., 2007). This quality is of great importance if we consider that people have a tendency to trust the

judgment of relatives and/or friends, and pay special attention to their experiences (Brown and Reingen, 1987, Robinson and Etherington, 2006).

In this view, we want to know to what extent the word-of-mouth has influenced the consumer's choice of hospital. With this purpose, we asked patients where they found the information to select public or private healthcare. Results are shown in Figure 6.

Figure 6: Spain *vs.* Italy – Word-of-mouth relevance



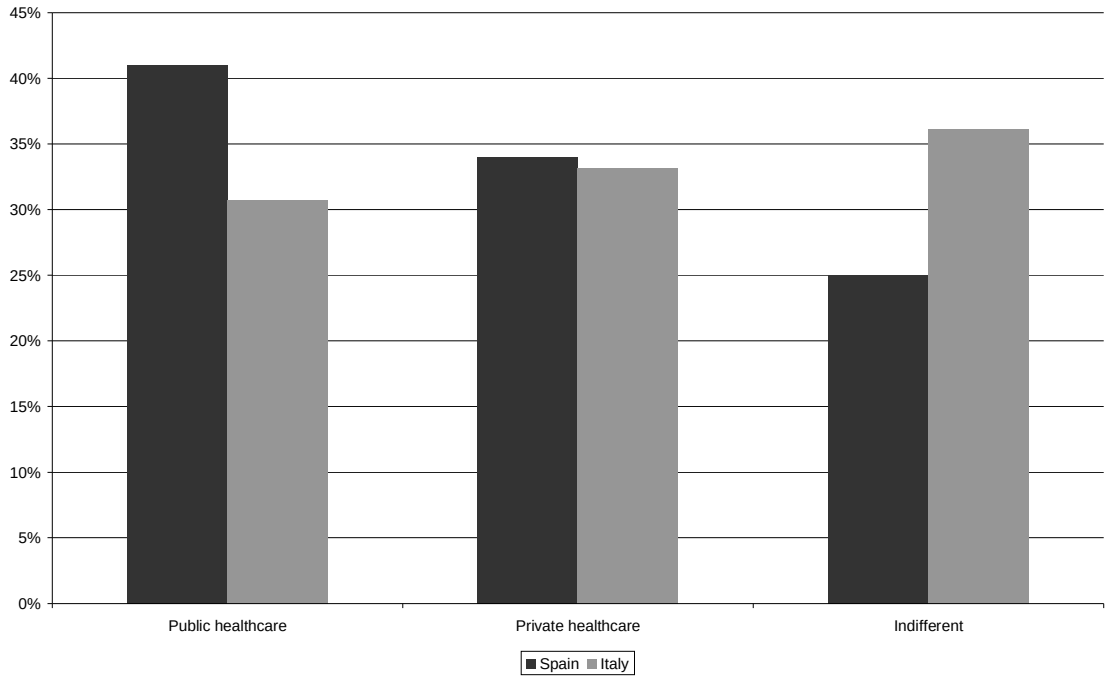
Source: Own elaboration

According to this Figure, both Spanish and Italian patients show a great trust in their familiar doctor, more Italian than Spanish. Second, Spanish patients rely more in friends than in relatives. However, if we consider together relatives and friends word-of-mouth, we appreciate that the main source for selecting healthcare provider is the word-of-mouth in both countries.

4.4 Behavioral intentions

Finally, as a result of these patients' perceptions, we focus on patients´ behavioural intentions in the future. Patients were asked what type of provider they would select in the future in order to be given healthcare. As we can see in Figure 7, results are different in each country. Spanish patients prefer public healthcare. However, Italian patients do not show any preference and, in case of having to select, they would choose private healthcare.

Figure 7: Spain *vs.* Italy – Behavioural intentions



Source: Own elaboration

5 Conclusions

The present study has proposed a comparison in a three-dimensional approach (2*2*2): 2 systems—public and private---; 2 healthcare services ---primary and specialized--- and 2 countries ---Italy and Spain---. Within this approach, a descriptive analysis has been performed, identifying differences between the public and private health service, both in primary and specialized care in both countries.

Implications for scholars interested in public services marketing are proposed in terms of the idiosyncrasy of health consumer behaviour: in particular, customer (patient) satisfaction and willingness to recommend a service provider (public or private) according to comparative service provision (primary or specialized care service), and geographical context (Italy and Spain). Implications for healthcare managers, although highly contextual, highlight the relevance of time management (paying attention to waiting times), the consideration of an experiential approach in health service provision, highly emotional, and the importance of word-of-mouth and behavioural intentions.

Our results mainly showed that, beyond cultural differences, we appreciate similar patients´ perceptions:

- There is not difference between Italy and Spain in waiting times. Both of them show less waiting time in private than in public healthcare.
- In spite of feeling lead and relaxed in both public and private healthcare, experienced sensations are better in private than in public healthcare in both countries.

- The main source for selecting healthcare provider is the word-of-mouth in Spain and Italy.

However, results about behavioural intentions are different in each country. Despite private healthcare show less waiting time and a better service experience, Spanish patients better prefer public healthcare. These results are probably due to the overall trust shown by Spanish citizens towards the Health National System, explained in our conceptual framework. However, it is important that managers consider these patients´ perceptions for better improving the service provided.

About Italian results, patients do not show preference for one or another type of provision. So, patients´ perceptions become essentials in order to be better preferred.

Two main limitations concern this study. The first one is conceptual and it has implications for the empirical results. Health service is very difficult to describe, so we have tried to capture its special idiosyncrasy through a number of variables, but it is more difficult and complex. Furthermore, we have not considered the coexistence of other management models, mainly public-private partnerships. According to this, new conceptual proposals, especially those based on combined and multidisciplinary models would be welcome in order to avoid having to oppose the public versus private model. The second limitation corresponds to the methodological procedure, which is merely descriptive: no significant differences have been measured between each pair of services (primary of specialized, public or private, Spanish or Italian). Further development of this study should bring more statistical knowledge on these (apparent) differences.

Nevertheless, our empirical study has tried to promote future research both from the academic point of view and from the empirical point of view, allowing comparisons between healthcare systems in different countries in order to learn from other systems strengths.

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