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The Effect of Financial Service Quality and Water Management on Patients' Satisfaction: Literature Review

Alashtar Mohammed Omar[1], S. M. Ferdous Azam[1]*
[1]Post Graduate Centre, Management and Science University, University Drive, Off Persiaran Olahraga, Section 13, 40100, Selangor, Malaysia
Email address: drferdous @ msu.edu.my

***Abstract*—** *Despite increasing interest in investigating the impact of perceived financial service quality and water management on patients' satisfaction, there is a lack of comprehensive research that reflects different financial environments, especially in the Libyan context after the 2011 revolution. This research will endeavour to investigate how perceived financial service quality and water management are related to patients' satisfaction. Its main objective is to investigate the impact of perceived financial service quality and water management in Libyan public hospitals are related to patients' satisfaction, the study aims to assess patient's expectations, patients' satisfaction levels and measure the quality gap for SERVQUAL dimensions. This conceptual study used the literature review to help in understanding in greater depth the impact of perceived financial service quality and water management on patients' satisfaction. It will help both the hospital industry and the government to develop new policies to attract more patients to undergo treatments in the local hospitals. Moreover, this will help the public hospitals to create sustainable competitive advantages in which their marketing strategies should be based to attract more potential patients from other countries.*

***Keywords*—** *Perceived; Financial; Service Quality; Water Management; Patients' Satisfaction; Libyan Public Hospitals*.

I. INTRODUCTION

The financial sector plays a vital role in people's lives today more than ever before. It is acknowledged that most people in developing countries are dissatisfied with the quality of financial services provided and desire for something to be done. "Libya is a country with unique values and distinctive heritage. The official language is Arabic, and the Libyan people are native Arabic-speakers. However, the English language is used extensively and is the teaching language in many schools and universities (e.g. linguistics, medical, dental). Culture and traditions are what differentiate a particular country from another (Ajaj, 2019). The influence of religion on most aspects of Libyan life is obvious, as the people practise their faith through their everyday actions. The Libyan culture is dominantly Arabic, sharing the same principles and values as other MENA countries (Ajaj, 2019). With a common language and religion, Libya appears socially homogenous (Alhmali, 2017). According to the WHO (2019), Libya has 96 hospitals offering a total of 20,289 beds, 25 specialised units with 5,970 beds, 1,355 primary health centres, 37 polyclinics, and 17 quarantine units. Libya has 10,230 doctors of whom 8,612 (84%) are Libyan, and 1,618 (16%) are foreign. This amounts to 1.7 doctors for every 1000 citizens. Furthermore, all Libyan citizens have access to financial services.

In Libya, evidence has shown that the financial sector is currently facing various challenges and difficulties. This is reflected by the increasingly common practice of paying personally for treatment abroad. Most of the Libyan population perceives the national financial sector as inadequate, and they are dissatisfied with all levels of services. However, Libya has succeeded in improving the quality of its financial services and in the general health of the population over the past few decades. Hence, this comprehensive study is an initial attempt to generate a reliable, evidence-based framework to assess the level of financial service quality (FSQ) and water management (WM). Quality in the financial sector is increasingly becoming a central health policy issue in the health systems of both developed and developing countries (Shaw & Kalo, 2002; Øvretveit, 2019).

Additionally, the interest in the general quality of financial has been impacted by political and financial imperatives, including limited resources, rising medical costs, and increasing consumer expectations. Thus, various financial reforms in many countries have emphasised the quality and efficiency of financial service policies and the need for a systematic approach to improve financial quality (Satia & Dohlie, 1999). In this regard, Øvretveit (2019) believed that there is a need to find an appropriate "way to quality" in developing countries because most people in such countries are not satisfied with the quality of public and private financial and feel that something should be done. In the Middle East and North African (MENA) countries, the quality of financial must attract growing interest in the past decades.

Besides, hospitals are expected to provide quality and 'zero defect' service to their patients. So, the satisfaction of patients has emerged as a crucial indicator as satisfying patients can help hospitals to reduce costs by cutting down the time spent in addressing patient complaints. The yearly cost of dissatisfaction with the services it provides for a hospital with 5000 annual discharges can be more than US$750,000 (Pakdil & Harwood, 2018). Adverse verbal testimony can lead to hospitals losing US$6,000 - YS$400,000 in lost revenues over a single patient's lifetime (Naidu, 2019). To provide quality

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services, it is crucial. First, there is a need to know what makes up quality service in financial. In respect of this, the current study is a pioneering attempt to facilitate the definition of the determinants and dynamics of financial service quality in Libya. According to Frisker et al. (2019), there can be an improvement in the quality of patient care only when the providers know how efficiently (or inefficiently) they are performing on key patient criteria. If the quality of financial sees no improvement, the outcomes can be worrying. Patients will be denied quick recovery; their costs will increase; poor quality will continue to be provided, and many patients will be persuaded to seek care elsewhere in other countries where they are assured of quality, and the local financial industry remains both unsatisfactory and unattractive.

The reluctance or inability of many developing countries to pay more attention and invest more in the financial sectors, the public is the impetus for many other countries to improve their quality of financial and profit from foreign patients through Medical Tourism. Savage, Campbell, Ford, and Van der Reis (2019) appear to be aware of such a scenario and have proposed that there should be studies conducted to investigate the challenges faced by some developing countries to improve and extend access to financial, reduce cost, and enhance quality. In the field of financial, there has been considerable research done to study how financial service quality is related to word of mouth. Encouragingly, there have been efforts made to study public hospitals that have employed the empirical approach to address this relationship (Arasli et al., 2018; Berendes et al., 2011; Cong et al., 2014; Yousapronpaiboon & William, 2019). It should be noted though that most of these published studies were conducted in North America, Europe, and significantly fewer in Asia as well as in MENA countries. These published studies focused on the quality of service and how it was related to WM in public hospitals (Al-Hawary, 2019; Diab, 2019; Mostafa, 2018; Zamil et al., 2019).

Hospitals are among the most energy-intensive facilities (Nusca, Funari & D'Alessandro, 2019), consuming more than twice the energy of offices or homes (Alfonsi, Capolongo & Buffoli, 2020). As argued by Capolongo et al. (2013), "although reducing health-related energy consumption and emissions alone will not resolve all of the problems of energy scarcity and climate change, it could make a meaningful contribution". Energy is needed to provide lighting (Buffoli et al., 2018), to power medical equipment, to heat water, to supply heating and air conditioning; Hospitals also produce waste and indirect environmental impacts are associated with their purchasing activities (Bottero et al., 2015). Bearing in mind the above, water consumption plays a primary role in the energy management of health facilities. Water in Hospitals is an essential element for hygiene and health; depending on the activities which take place within the structure, Hospitals require a significant quantity of water per day, to be used in different ways and for different purposes (D'Alessandro et al., 2016). For example, water for human use and/or food consumption has different quality characteristics compared to rehabilitation swimming pool water, sterilizers, and dialysis water or even irrigation water (World Health Organization, 2010).

Libyans have been suffering from the deterioration in the provision of financial services. While financial services are available and accessible, its utilisation is still limited. This is due to ineffective financial facility infrastructures; poor chains of supply; shortages and inadequate equipment; poor HR recruitment, and weak leadership and commitment. Such issues have a negative impact on the quality and safety of financial provision. Hence, the public's confidence in the financial service is at its lowest in Libya. Several attempts have been made to re-engineer the Libyan financial system and assess water management in both public and private hospitals in Libya after the Libyan revolution in 2011. The problem that this research seeks to address is the current poor quality of financial and water management services being provided to patients which result in patients' dissatisfaction. There is no reason for not improving the quality of Libyan financial services, and with the availability of advanced technology at affordable prices, there are ample opportunities for improving information exchange and other aspects related to financial that will boost the quality of financial in the Libyan context. The aim of this research is to investigate the impact of perceived financial service quality and water management on patients' satisfaction.

II. Literature Review

Financial Service Quality in Financial System

Defining and determining financial quality is always a challenge because it is not measured by the service provider by the customer/patient whose main concern is personal health (Eiriz & Figueiredu, 2018). For this reason, some researchers have suggested that the most reliable source of information related to patient satisfaction would, therefore, be family members and friends, Furthermore, such observers – family members and friends are also potential future customers besides being important collectively as an influential factor in patient financial choices (Strasser et al., 2018; Naidu, 2019).

Several researchers have proposed the need to empirically study the cross-cultural aspects of financial service quality and patients' satisfaction (Zineldin, 2016, and Badri et al., 2018). Previous studies have suggested that what patients expect and what they prioritise may differ from country to country due to differences in culture and the dynamics of the country's financial system (Eiriz & Figueiredu, 2018). Furrer et al. (2019) showed that weak customers in large power distance cultures put less emphasis on reliability, empathy, and responsiveness. It has been reported in various studies that in different countries, customers evaluate service differently because their perceptions of FSQ differ among different customers. As such, the measurement tools and the dynamics of evaluation that work well in one country need not necessarily work as well in another country or culture. Other studies have also indicated that because customers respond differently and interpret various items differently, the dynamics of measuring of FSQ and customer satisfaction can differ substantially across cultures (Tsoukatos & Rand, 2017; Malhotra et al., 2018).

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Service Quality

One of the most explored disciplines in service marketing is service quality (Thawesaengskulthai et al. 2015). As mentioned by Thawesaengskulthai, et al. (2015), many previous studies have connected SQ to customer satisfaction (Cronin & Taylor, 1992; McAlexander, Kaldenberg, & Koenig, 1994), behavioural intention (Headley & Miller, 1993; Zeithaml, Berry, & Parasuraman, 2017) and value and satisfaction (Cronin, Brady, & Hult, 2019). Service quality perception has commonly established that financial service quality is a multi-dimensional, higher order construct and there has been no consensus among researchers regarding whether SQ perceptions should be measured or not (Gronroos, 1984; Parasuraman, Zeithaml, & Berry, 1988). Similarly, Pollack, (2018) argues that service quality is a multi-dimensional construct and researchers have suggested a range of SQ determinant factors. For instance, Gronroos (1984) pointed to two categories of SQ: technical quality (i.e. what the customers receive from the service), and functional quality (i.e. how the service is rendered). Gronroos (1984) has also recently proposed that SQ can be holistically defined to encompass professionalism and skills, attitudes, and behaviour, being accessible and flexible, reliable, and trustworthy, service recovery, servicescape, reputation and credibility (Gronroos, 2019).

Originally, SERVQUAL had ten dimensions of SQ: security, competence, reliability, courtesy responsiveness, accessibility, credibility, communication, awareness, and knowledge of the customer and tangibles. Generally, the most accepted concept of SQ encompasses five dimensions, namely tangibility, reliability, responsiveness, empathy, and assurance (Parasuraman et al., 1988). In the early 1990s, the model was popular as RATER, which is the acronym for Reliability, Assurance, Tangibility, Empathy, and Responsiveness (Chan et al., 2017). In the SQ Model proposed in 1985, there were ten dimensions discovered. For the purpose of examining the dimensionality of the scale, the reliability of the components and the development of the instrument to measure SQ in 1985, Parasuraman et al. conducted a quantitative research approach to establish an instrument to measure SQ, now widely known as SERVQUAL, which is used "to measure customer perception of SQ in service and retailing firms." The instrument's definition of SQ refers to a particular attitude, associated with but not quite the same as satisfaction, which is derived from a comparison of what a consumer perceives and what is expected of the service experience (Parasuraman, Zeithaml, & Berry, 1988). A premier quality financial service is the primary significance of the health sector in the 20-year vision document as SQ is a fundamental concern in the financial sector (Ali, Hamid, & Emadi, 2015). SQ is recognised as a multi-dimensional construct (Pollack, 2018) and scholars have provided a range of SQ determinants (Teshnizi, Aghamolaei, Kahnouji, Teshnizi, & Ghani, 2018).

Financial Quality Dimensions

Perceived FSQ is the result of the evaluation of the comparison of consumer expectations with the service that they have received (Gronroos, 1984). In other words, perceived FSQ is the difference between the perceived service and the expectation of the actual service provided. Gronroos (1984) suggested that FSQ encompasses two distinctive elements. The first is known as the technical aspect which defines WHAT is provided, and the second is known as the functional aspect which defines HOW the service is provided. Quality has been defined as perceived satisfaction (Smith & Swinehart, 2001). Koch, (1991) defined quality as continually satisfying patient requirements. It is a form of attitude, related to but not the same as satisfaction, and the results are obtained by comparing expectations with perceptions of performance (Parasuraman et al., 1988; Zeithaml, 1988; Lim & Tang, 2019; Sureshchandar et al., 2002).

There is no consensus on the number of components underlying patient perception of the financial service quality and patients' satisfaction. Hall and Dornan (1988a) conducted a meta-analysis involving 221 studies on patients' satisfaction and quality of health services. They showed that 25% of the studies used only one dimension (although multiple items were used to refer to that dimension), 46% of studies used two to four dimensions, and the other studies included five or more dimensions. Taking into account the potential shortcomings of multi-dimensional measures of patients'' perceptions of financial service quality and patients' satisfaction fails to consider all aspects of satisfaction important to patients (Ware et al., 1978), and it is wrong to equate all information derived from satisfaction surveys (Ware et al., 1983). The existing literature has developed frameworks to identify the dimensions of FSQ. In one of the early studies on FSQ Bernhardt and Shostack (1983) suggested that quality of a service can be experienced during a service (i.e. functional quality) and on completion of a service (i.e. technical quality). The authors also suggested that customers' experience of both functional and technical quality should be matched against their expectations. Subsequently, this has resulted in the development of the GAP model where FSQ is measured by the difference between expectation and perception scores (Parasuraman, Zeithaml et al., 1988). These scores are rated concerning five FSQ dimensions, which are: tangibles, reliability, responsiveness, assurance, and empathy. Collectively, they represent the SERVQUAL instrument, which was claimed to be generic and could be applied invariantly across different contexts(Yuen & Thai 2015).

Patients' Perception of Financial Quality

Research on evaluating financial service quality in the financial industry from the user's perspective is often conceptualised as patient satisfaction, which has been extensively studied over the years. A definition of satisfaction is "fulfilling expectations, needs, or desires" (Sitzia & Wood, 2017). Satisfaction suggests that financial users compare their expectations against the actual service and that this leads to either a positive or negative feeling. If expectations are exceeded, financial users are more satisfied (Harteloh et al., 1992). Because satisfaction is a result of both expectations and experience, variations in scores can be a result of differences in expectations or experiences (Sixma et al., 2018). For example, when financial users have unrealistically high

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expectations, their experiences will never meet these expectation criteria thus resulting in low satisfaction. This is a serious problem when patients' perceptions are used as a factor in identifying better performers, or where improvements in financial service quality are needed (Sofaer & Firminger, 2018). To overcome this, considerable effort has been made to develop a method to 'report about events' (experiences). A definition of reporting on events is "Reports on experiences illustrate if financial users did or did not experience action in their interactions with financial providers and the financial system' (Browne et al., 2018). Reporting on events tends to reflect the quality of care better. Also, this type of reporting is more interpretable and actionable for financial service quality improvement purposes (Sixma et al., 2018).

Although professionals' and other financial stakeholders' perceptions of the quality of financial services are important for this study, patients' perceptions are the focus in this part. A salient theme is that FSQ differs from manufacturing quality, and thus different considerations must be considered when evaluating it. FSQ is a multidimensional, value-laden concept and therefore different stakeholders (patients, doctors, managers, etc.) will have different perceptions and opinions regarding its value and assessment (Øvretveit, 2018). It is increasingly being recognised that patients' perspectives on quality, alongside those of other stakeholders, are very important in any quality initiative. A wide range of contexts can be identified to explain the growing importance of eliciting patients' perceptions in general. For example, there is a quality agenda where patients' perceptions are increasingly seen as an essential part of service evaluation (Øvretveit, 2018; Hall, 2019). Another context is the tendency, at least in Western societies, to emphasise a political perspective and the need to democratise or counteract the democratic deficit in financial services through public participation and a market economy approach to financial services (Harrison et al., 2002a; Harrison et al., 2002b).

Considering patients' perceptions is vitally important for the general evaluation of financial quality because if they are not taken into account, negative patient attitudes may affect the impact of quality programmes – patients might not comply with treatment, miss appointments, be unhappy, dissuade other patients, not get better, and adversely influence the outcome of the health service. Moreover, the managerial (economic efficiency) and professional (clinical effectiveness) agendas of quality programmes may be unachievable if patients' perceptions and perspectives on quality are not synthesised and amalgamated in a quality evaluation initiative. There is agreement among scholars that the quality of financial is a multi-dimensional concept, and it has been given different meanings in the literature. As Larsson and Larsson (1999:34) indicate, "Patients' views on what is important in connection with the care they receive may be seen as one aspect of quality of care, and WM has increasingly come to be used as an indicator of this quality." Consequently, patients' perspectives of what constitutes good quality of financial are increasingly recognised as an important source of quality indicators.

III. Research Methods

This conceptual literature review manuscript explored the scientific literature provided by the major publishers regarding project management including books, journals, conferences, as well as previous relevant studies handling the perceived financial service quality and water management on patients' satisfaction. The next section will highlight the major concerns.

IV. Discussion

Understanding the content and organisation of patient expectations will enable the financial provider to respond positively and proactively. To satisfy its customers, an organisation must know what the customer needs and expects, and if these needs and expectations are met with the right product or service and well delivered, customer satisfaction will be achieved (Friesner et al., 2019). Jackson et al. (2001) proposed that immediately following the visit, patient satisfaction can be cemented by patient-doctor communication variables as satisfaction is influenced by both patient's age and functional status. They posit that patient satisfaction is utilised for four purposes: (1) for comparison of different financial programmes or systems; (2) for the evaluation of the quality of care; (3) for identifying which aspects of a service need to be modified to enhance patient satisfaction, and (4) for assisting organizations in identify consumers who may wish to dis-enrol.

Many studies have applied different constructs (or factors) in representing "satisfaction" (Ygge & Arnetz, 2001) while others have included satisfaction into their survey instrument by requesting participants directly to show their satisfaction with care for each item representing financial quality (Badri et al., 2019). Senarath et al., (2016) believed that WM could be assessed by a 16-item instrument covering several key dimensions of client satisfaction: accessibility, interpersonal aspect of care, physical environment, technical aspects of care, and outcome of care. WM can be predicted by factors associated with caring, empathy, reliability, and responsiveness (Tucker & Adams, 2001). Other dimensions have also been used to obtain patients' financial assessments (Fowdar, 2018), such as core services; customisation; professional credibility; competence; and communications.

However, patient satisfaction is a complex concept and difficult to measure, so that many hospitals that wish to implement new strategies based on the patient's desired service have found that the process of identifying the preferences of medical service from patients' perspective would be very difficult (Ali, Hamid, A., & Emadi, 2015). Izogo, and Ogba, (2015) and Etemad-Sajadi and Rizzuto (2019) believe that FSQ improvements are the key to satisfaction. As such, Taap et al. (2011) had earlier argued that organisations had shifted attention to the importance of maintaining competitiveness using measuring their FSQ from the eyes of customers through initiating major FSQ change programmes because poor FSQ results in higher costs of acquiring customers to replace those who have been lost.

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As has been indicated by many studies, patient satisfaction is accepted as one of the most crucial dimensions and key success indicators in financial (Pakdil & Harwood, 2018). Zineldin (2016) maintains that satisfaction as "an emotional response." Although seemingly similar, perceived FSQ and consumer satisfaction are distinctly different constructs that could be described and assessed differently, whereas FSQ and consumer satisfaction have some commonalities: satisfaction is usually perceived as a broader concept whereas FSQ assessment highlights the dimensions of service (Zeithaml & Bitner, 2019). Normally, FSQ is recognised as mainly a cognitive construct whereas satisfaction has been viewed involves greater conceptual complexity that encompasses cognition and affective components. Satisfaction is considered as an attitudinal response to value judgments made by patients concerning their clinical experience (Kane et al., 2017).

Satisfaction, on the other hand, is viewed as a universal consumer response and a consumer's reflection on their degree of pleasure and based on service delivery predictions/norms that are dependent on previous experiences that are conceptually driven. However, perceived FSQ could change with each specific experience and is likely to last longer than satisfaction, which is known to be transitory and is only the reflection of a particular service encounter. (Vinagre & Neves, 2018). Oliver (2017) defined satisfaction as "the consumer's fulfilment response," a post-consumption assessment by the consumer that a particular service induces a pleasing level of consumption-related fulfilment, including under- or over-fulfilment. The study identified some major elements that separate FSQ from satisfaction and suggested that quality is an assessment or evaluation of a performance pattern involving several service dimensions related to the service provided. Quality, on the other hand, is believed to be determined more by external factors.

SQ can be investigated as the overall experience in financial. Priporas, et al. (2018) indicated that a patient's expectations and perceptions are not merely related due to a medical or health service, which is not technically comprehensive. Patients, therefore, are not able to clearly understand their expectations in a clinical setting. The literature review of methods used to obtain patients' perceptions of the quality of financial indicates that there are several approaches to measuring patient perceptions. These main broad categories can be grouped primarily into (i) quantitative research derived from positivistic inquiry, and (ii) qualitative research (Neuman, 2017; Bruster, 2018). These approaches include, for instance, counting and categorising complaints, examining critical incidents and adverse events, and satisfaction surveys (Bowling, 2002). The following sections elaborate on these two approaches.

Several instruments have been developed to assess patient satisfaction (Beattie et al., 2002; Castle et al., 2018). These instruments nearly all ask patients to evaluate the services received at either a global level (e.g. overall satisfaction with financial) or a service-specific level (e.g. satisfaction with nursing care). Prior research (Wensing et al., 2018) attempted to empirically examine which components of financial are important and related to the quality of financial. In their study to identify patients' priorities in general practice, Grol et al. (1999) asked 3,540 patients from different European countries to prioritise 38 items of financial. They found that the top ten items identified by patients were related to access, the doctor-patient relationship, communication, competence, courtesy, and respect for privacy. Similarly, Bower (2017) identified two "overarching" domains related to quality: access (namely are care facilities accessible when needed) and effectiveness, which can be further divided into the quality of technical care and the quality of interpersonal care (such as whether care if any good when accessed). Moreover, Bower identified a list of eight further sub-domains relevant to patients' assessments (Bower, 2017): service access, quality of specialised care, the doctor-patient relationship, continuity, coordination, and organisation of care.

The measurement method most commonly used was the Likert-type scale: a "quality rating" that ranges from "excellent" to "poor" or a "satisfaction scale" ranging from "very satisfied" to "very dissatisfied," or a "declarative scale" ranging from "strongly agree" to "strongly disagree" (Rosenthal & Shannon, 2017). Similarly, Parasuraman et al. (1988) developed a 22-item SERVQUAL scale to measure the quality of services in retail industries. This scale was later adapted to health services (Babakus & Mangold, 1992) and included questions about patients' perceptions of the actual service delivery and expectations of the hospitals in providing these services. Sixma et al. (2018) concurred with Pascoe regarding the lack of a theoretical framework in WM research, and commented that: "Theory and methodology in this field appear to have developed along separate lines of interest." However, they refuted the idea of dissimilarity between market-based research and WM research. They claimed that the business based SERVQUAL model of consumer satisfaction, developed by Parasuraman et al. (1994), could fill the gap between theory and practice in WM research.

According to Haddad et al. (2018), confusion about the meaning of quality has slowed progress, and the general assumption that PHC simply consists of services which do not require or possess complex technologies has led to less urgency in setting quality standards. Furthermore, the quality of financial in developing countries is usually defined and expressed by health professionals from a technical perspective. The delivery of quality health services is a major challenge that health service providers face by emphasising the importance of patient perspectives in assessing quality in health services (Tangcharoensathien et al., 1999; Andaleeb, 2001; Alasad & Ahmad, 2017). Haddad et al. (2018:381) noted the recent rise in interest in the quality of financial in developing countries, and the practical steWM, actions and studies being taken to ensure acceptable standards of quality. According to them, such a trend "undoubtedly translates the concerns raised by the implementation of strategies to improve the continuity and effectiveness of services. It is also the consequence of the repeated observation of strong links between the quality of services and the use of these services."

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V. CONCLUSION

The findings of this study also have enlightened hospital management in both Libyan public hospitals in identifying the dimensions of FSQ that influence service environment and WMS. Priority of the hospitals is to draw attention to the dimension depending on the origin type of hospital. In Private Libyan hospitals, tangibility and reliability are the most important dimensions in determining service environment and WMS, respectively. The Private Libyan hospitals could offer better patient satisfaction by emphasising these two dimensions, whereas, in Libyan Public hospitals empathy and assurance is the most important dimension in determining service environment and WMS, respectively. Libyan Public hospitals could achieve better WMS by emphasising these two dimensions. Hospital management in public hospitals should focus on the most important dimensions in their overall FSQ. The Private Libyan hospitals should emphasise the institution's ability to manage the tangibility dimension and improve the assurance and empathy dimensions while Libyan Public hospitals should stress tangibility and reliability while boosting the most important dimension, which is empathy. Given that reliability, assurance and empathy are mainly human interaction, both types of hospitals should invest financial resource in training programmes to raise staff awareness on the importance of these dimensions in achieving better WMS and implant a culture of service excellence in the hospital's vision and mission.

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