MEASURING THE PERCEPTION OF QUALITY MANAGEMENT PRIMARY HEALTHCARE SERVICES THROUGH SERVQUAL MODEL

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Abstract

The quality of healthcare is more difficult to identify than other services because it is the clients themselves and their quality of life that gets evaluated (Eiriz & Figueiredu, 2005). The main aim of this study is to investigate people's perceptions and expectations regarding the quality of services in primary health care (PHC) in Kosovo. A national level survey provides baseline findings intuitively understandable to policymakers on the expectations — perceptions of the quality of services at the PHC level and identifying the quality gap between the expectations and perceptions in all dimensions of different facilities. This comparative test will show the differences between the level of quality services provided by each PHC provider in Kosovo. This research seeks to improve the access and the quality of the priority services at PHC, including maternal and child health (MCH) and non-communicable disease (NCD). This research showed that at the national level the patients have higher expectations toward PHC services. Whereas, in specific, this study showed that there is a significant gap in expected and perceived services of the PHC system between different ethnic patients and different levels of citizen education. Therefore, the result of this study will contribute to enhancing the sustainability of the mandatory health insurance reform and raise the alarm of relevant institutions to reshape the policy-making in order to improve the population health outcome.

Keywords: Service Quality, Expectations, Perceptions, Primary Health Care, SERVQUAL, Kosovo

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1. INTRODUCTION

As for patients, "perception of quality" means how well the service is provided. It can be considered one of the desired outcomes of care and therefore information on patient satisfaction is required to assess the quality and planning of healthcare management (Turner & Louis, 1995; Naidoo & Wills, 2009; Alrubaiee & Alkaa'ida, 2011). Ultimately, Gulas et al. (2014, as cited in Georgiadou & Maditinos, 2017) conclude that, in healthcare units, the aim must be a culture of quality and continuous improvement with a reference point for the citizen. This is also supported by a conducted study by Aiken et al. (2012) about patient safety, satisfaction, and quality of hospital care: cross-sectional surveys

of nurses and patients in 12 countries in Europe and the United States, are linked to the quality provision of healthcare services and work environment and consequently suggests that improvement of healthcare quality service and work environment might lead to the improved citizen's perception of the healthcare service quality.

Such studies on measuring perceptions on quality in the health sector in Kosovo affect the establishment of health care and the efficiency of providing quality services, developing a range of services for vulnerable groups facing various barriers to access to services. In particular, research on perceptions and expectations regarding PHC of Kosovo aims to establish access to and quality of primary health care (PHC) services, contributing to improving the sustainability of mandatory health insurance reforms and improving the health outcomes of the population. The purpose of this study is to provide baseline data intuitively understandable to policymakers on the perception and expectation of the population regarding the quality of services in PHC in Kosovo. Additional objectives were to evaluate the gap of each dimension, determine whether the socio-demographic factors influence it, and highlight which dimension is the most important for patients. The recent previous reports were to measure the quality of care related to structural and procedural aspects of PHC in all 38 municipalities in Kosovo as the report of the World Health Organization (WHO, 2019) on primary health care in Kosovo, or studies on patients' evaluation of PHC services was focused in one region of Kosovo (Tahiri et al., 2014). Therefore, our study, in order to be more comprehensive, aims to present the results on the expectations and perceptions of the quality of services at the PHC level and identify the quality gap of the expectations-perceptions in all dimensions of different facilities.

In general, this paper processes the research based on the gaps model methodology of service quality and SERVQUAL instrument (Parasuraman, Zeithaml, & Berry, 1988).

The remainder of this paper is structured as follows. Section 2 reviews the relevant literature. Section 3 analyses the methodology that has been used to conduct empirical research for measuring the perception of quality management of primary healthcare services in Kosovo through the SERVQUAL model. Section 4 contains summarized and analyzed results of this study and discusses the overall and specific findings of different variables of this study. Whereas Section 5 generates relevant conclusions, study limitations, and the importance of this study paper for future research.

2. LITERATURE REVIEW

Service quality has drawn the attention of researchers as well as practitioners in various disciplines including health care services. Therefore, studies and research on PHC services have demonstrated major opportunities for improvement of the performance of health care processes in at least four areas: health status outcomes, service characteristics (measures of satisfaction), breadth of access, and levels of waste (Juran & Godfrey, 1988). Service quality is the result of the quality expected and obtained. Quality takes precedence over other elements of service provided and is thus given a priority. The SERVQUAL gap model enables the identification of five gaps/discrepancies and the factors that relate to them, making it possible to determine the service quality provided (Jonkisz, Karniej, & Krasowska, 2021).

In addition, it is very important to establish a relevant and sustainable motivation system for healthcare providers to optimize their work quality (Ivanov et al., 2022).

The concept of quality is directly related to the manifestation of service, considering that the product is obtained as a result of a process; it includes both goods and services (Juran & Godfrey, 1988). It becomes complex when the item being judged in terms of quality is a service (intangible) and not a product (tangible) (Hill, 1999). According to Parasuraman, Zeithaml, and Berry (1985), service quality can be defined as "the degree and direction of a discrepancy between consumer's perceptions and expectations in terms of different but relatively important dimensions of service quality which can affect their future purchasing behavior" (pp. 41–45). Whereas the dimensions of service quality are interconnected with customer perceptions of quality are influenced by the manner in which the service is delivered (e.g., functional quality) as well as by the outcomes (e.g., technical) and the physical aspects of the service (equipment) (Kenyon & Sen, 2015).

Furthermore, according to Itumalla, Acharyulu, and Shekhar (2014) and Georgiadou and Maditinos (2017), recognition of the importance of quality of service is imperative, not only to provide better services to patients but also to ensure the initial viability of the hospital and then its sustainable competitive advantage. Concerning health service quality, the main difference between health services and other services is that they are based on patients' needs and not on customers' desires (Sarris, 2001). Therefore, the health care customer is the patient, who is the focus of its implementation system. Eiriz and Figueiredo (2005) commented that the quality of healthcare is more difficult to identify than other services because it is the clients themselves and their quality of life that gets evaluated. For patients, "quality" means how well the service is provided and not if the actual service is technically superior (Georgiadou & Maditinos, 2017).

In Kosovo, fewer people than in other European countries are satisfied with their visits to PHC (Tahiri et al., 2014) and studies indicate that patients' expectations for PHC services in Kosovo have not been met (WHO, 2019). PHC capacity, in terms of team composition, competencies, and available equipment, does not match the health needs and expectations of the population, which leads to decreasing prestige and bypassing of PHC services (WHO, 2019).

In Kosovo, health reform programs were lauded as a success given the evidence-based, organized, and orderly nature of the policy generation process (Shuey, Qosaj, Schouten, & Zwi, 2003, pp. 299–310). However, the implementation of these reforms is more problematic than their creation, more research studies are necessary before concrete policy recommendations can be developed in the context of a difficult process of transforming and strengthening the health system. To provide an analytical background for drafting this secondary research related to the survey on perceptions of a population of quality services in PHC, this study has conducted

the following analysis: 1) analysis of the healthcare system in Kosovo, and 2) analysis of the quality of the public healthcare system in Kosovo with the focus on the quality of services in PHC. In this context, analyzing national survey results of service quality, a gap that may exist between people's expectations and perceptions of service quality in PHC of Kosovo will be predicted.

2.1. The healthcare system in Kosovo

The healthcare system in Kosovo had been undergoing difficult challenges for two periods: before and after the conflict of 1999 in Kosovo. Before the conflict of 1999, Kosovo had inherited a Semashko healthcare system with centralized decision-making and emphasized specialization of services. After revoking the autonomous status within the Republic of Serbia in 1989, the health sector in Kosovo became a natural battleground for the conflict between Kosovo's majority Albanian population and the federal government in Belgrade (Percival & Sondorp, 2010). Between 1989 and 1999, the Serbs fired most Albanian health workers (Buwa & Vuori, 2007). Furthermore, during the 1990s, more than 50% of Albanians lacked a social insurance card needed to access the public health system. To respond to this need, Albanians organized a parallel primary healthcare system that was established in the early 1990s, known as the "Mother Theresa Society", which operated 96 clinics throughout Kosovo, many in remote areas. Many Albanian health professionals also established private healthcare facilities, including clinics and laboratories, during this period.

After the conflict of 1999, the parallel Mother Theresa Network was virtually abandoned, and Albanian health professionals moved back into state health facilities. But the healthcare system seriously deteriorated after years of economic and political turbulence. The collapse of the public-service infrastructure, particularly water and electricity, deeply affected the health sector (Buwa & Vuori, 2007). Health clinics in rural areas suffered from an acute lack of personnel and equipment. It was revealed that the current health system was inequitable and inefficient. The health sector reforms initiated by the international community were desperately needed. It was purported that one-in-three Kosovars could not afford to access health care when ill (Campbell, Percival, & Zwi, 2003).

2.2. The quality of the public healthcare system

According to Percival and Sondorp (2010), the quality of the public healthcare system in Kosovo was compromised by several factors. Access to primary care was inconsistent across regions and socioeconomic groups. Shortages of health personnel in rural areas, the specialized nature of healthcare in Kosovo, and the lack of a functioning referral system undermined the quality of care. Moreover, the efficiency of services was minimal. While the shortage of physicians and the poor state of health facilities contributed to variable access to healthcare, economic factors also impacted the ability of individuals to access health services. The World Bank (2001) found that the main barrier to healthcare was cost, even though healthcare was supposed to be free; 28% of those surveyed reported that they could not access health services due to expense. Co-payments and under-the-table payments placed an even heavier burden on the poor. Over 95% of them reported buying healthcare services. The average household spent 35 euros annually on drugs.

Quality indicators have been prepared and implemented through the contracting system which began in 2013 (Osmani, Marušic, Halimi, Muharremi, & Prevolnik Rupel, 2017). The quality of health care services comprises two main elements: clinical and patient satisfaction. Quality issues include lack of basic supplies, essential medical equipment, staff absence during working hours resulting in long waiting times, poor staff attitudes, friends of medical staff being given priority over others who have waited longer, poor complaints handling, poor hygiene conditions, lack of information from staff either verbally or through information materials; and "no tolerance" for patients who have special needs.

Concerns about the quality of service do not leave the public sector intact. Some researchers suggested that when it comes to the assessment of quality, the understanding of people's expectations is a key element (Parasuraman, Zeithaml, & Berry, 1991). The gaps model of service quality and its SERVQUAL instrument are among the best-known and most commonly used multidimensional models for measuring service quality (Ozretić Došen, Škare, Čerfalvi, Benceković, & Komarac, 2020). Understanding and measuring service quality from a patient's point of view is important because it is integral to the provision of better services to the patients. Consequently, quality is defined as the difference between predicted or expected service and perceived service. A gap between the two does not necessarily mean low-quality service but rather that the expectations of the patients have not been met and this is a source of dissatisfaction. A truly patient-centred approach should take this gap into consideration. This means that unless both perceptions and expectations are measured, it is difficult to identify and prioritize improvements that are required in service to ensure that patient's needs and expectations are met. If a health service is to be perceived as satisfactory, it needs to take into consideration such expectations. By paying respect to people's expectations, health care services are able to maintain the public's trust in them and play a vital role in the course of the patient's treatment.

3. RESEARCH METHODOLOGY

The methodology used for this study is relied upon the gaps model methodology of service quality and the SERVQUAL instrument, as a multiple-item tool scale for measuring consumer perceptions of service quality.

In general, in the whole territory of Kosovo, there are around 430 primary healthcare service providers, out of which around 20 to 22 are located in 3 Kosovo north municipalities and 408 in the rest of Kosovo. In specific, out of 408 health care providers in the rest of Kosovo, 28 of them are the main centres of family medical health care, 153 are centres of family medical health care, and 227 are ambulances of family medical health care. Quantitative and qualitative data were gathered through a national survey with 1,731 patients throughout Kosovo.

A cross-sectional study was carried out at PHC (at 30% of primary health facilities) in urban and rural locations across 29 municipalities. Quantitative and qualitative data were gathered through a national survey with 1,731 patients throughout Kosovo. The sample was chosen randomly at each of the municipalities. The participants were approached by a trained interviewer as soon as they arrived at the PHC, and they were asked to participate in the study. They were assured of the anonymity and confidentiality of their responses.

3.1. The instrument

Two basic models were used for drafting the questionnaire: the SERVQUAL model and some modules from the one of AQH (Accessible Quality Healthcare project in Kosovo, https://aqhproject.org/). The SERVQUAL model, presented by Parasuraman et al. (1985), gives attention to "perceived service quality" which is the difference between people's expectations and perceptions. SERVQUAL is a valuable tool for assessing the quality of health care services (Asubonteng, McCleary, & Swan, 1996) in different countries (Anderson, 1995; Sargeant & Kaehler, 1998). SERVEQUAL instrument is a useful measurement instrument tool in assessing and monitoring service quality in hospitals (Isik, Tengilimoglu, & Akbolat, 2011). SERVQUAL model gives the opportunity to health services to identify a number of areas for potential improvement in service quality (Gholami, Kavosi, & Khojastefar, 2016). It measures the gap between customer expectations and experience. The model was refined to the useful acronym RATER: reliability, assurance, tangibles, empathy, and responsiveness, as it allows one not only to estimate the overall level of satisfaction but also to identify dimensions where experience transcends expectations (an excellent service) and dimensions where experience falls short of the expectations.

The questionnaire is divided into 5 sections and a socio-demographic data section. It contains 78 questions, mainly structured ones. The answers were evaluated by a Likert scale from 1 to 7 for the questions of sections A, B, and E of the questionnaire. If the respondents strongly agree with the declaration, they should circle the number 7. If they strongly disagree with the declaration, they should circle 1. Otherwise, they should circle one of the numbers in the middle.

The questionnaires were prepared in two languages: Albanian and Serbian. Questions in the Albanian language questionnaire were adapted to the local and linguistic context of Kosovo, taking into account the national norms of the statistical process control (SPC) as well as WHO norms.

3.2. Sample

A cross-sectional study was carried out at 30% of primary health facilities in urban and rural locations across the 29 municipalities. Quantitative and qualitative data were gathered through a national survey with 1,731 patients throughout Kosovo. The sample was defined as all individuals of all ethnic groups, aged more than 18 years old that visited a particular public PHC centre located in the populated urban and rural area of Kosovo at the time the interviews were conducted. As the proposed sample of this study was aimed to best represent the specific targeted population groups and subgroups, we proposed a sample of 30% of the actual total number of around 430 primary health care providers and is accounted for 1700–1800 individuals. The sample was proposed to be chosen randomly in each municipality, all around Kosovo. They were assured of the anonymity and confidentiality of their responses. At this point, participants were given the expected version of the SERVQUAL questionnaire. The survey was piloted in advance and tested the instrument in 7 health settings: Main Family Medical Centre (*Qendra Kryesore e Mjekësisë Familjare* — QKMF) Prizren, QKMF Prishtinë, QKMF Ferizaj, QKMF Gjilan, QKMF Peje, QKMF Gjakove, and QKMF Mitrovice, on the period of December 28, 2018, to December 30, 2018. The outcomes were analysed and it was medicated and improved the instrument and then it was finalized.

3.3. Data collection

The data were gathered by well-pre-trained interviewers, some of them could also handle the interviews in other ethnic languages. The group that interviewed relevant respondents consisted of 15 persons, and they were spread out into different geographic areas at the national level. Most of them had previous experience with surveys. Data collection was realised in the period of January 5–20, 2018. The data was collected and then they were structured in excel format to make them ready for processing electronically, with SPSS Statistics software, model 20.00.

Before the interviews, participants were given an information leaflet and asked for their consent. For this, participants were informed that a) their participation is voluntary, b) they can withdraw from participation at any time without any consequences, and c) non-participation will not have any negative effects. Participants were informed how the data will be used and that confidentiality is ensured as no names or other identifying aspects will be collected. Ethical clearance will be required from the Board for Ethical-Professional Supervision.

3.4. Data analysis

The data analyses were structured, we processed all received data in a computerized system/application such as SPSS Statistics software and analyzed them in detail. In this context, data analysis will consist of examining, categorizing, tabulating, and recombining the evidence obtained from the research in order to discover any important underlying patterns and trends. The relevant gathered data will be analyzed through the following methodologies:

Descriptive analysis: In the framework of this research analysis, consideration is given to the primary information collected from targeted groups by building a descriptive logical framework based on the above-mentioned gathered information for the perception of the level of quality services provided by each PHC provider.

Comparative analysis and comparison tests (test of differences): To see the differences between the level of quality services provided by each PHC provider and the citizens' desired level of health care services.

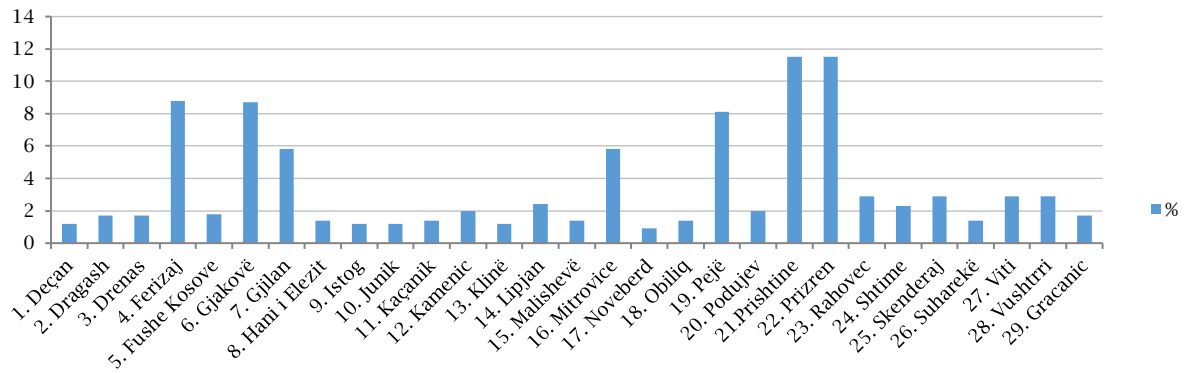
Factorial analysis: Factorial analysis is a common technique used to reduce the number of variables, and to provide evidence of the validity of the construct of the questionnaire. An important aspect of this analysis goes to the Kaiser–Meyer–Olkin (KMO) test and the Bartlett test, playing an important role in accepting the sample accuracy. Also, the Bartlett test relates to the importance of the study and shows the validity and appropriateness of the responses collected from the instrument used in the study.

4. RESULTS AND DISCUSSION

In general, patients have high expectations of the services of PHC in Kosovo. Female patients had higher expectations than men, the same was with perceptions too. Young patients (18–24 years old) had also higher expectations toward the healthcare services in PHC in Kosovo, while the patients more than 65 years old had higher perceptions. Albanian patients had higher scores on both, expectations and perceptions too. While the patients who had completed the university had a higher level of expectations, those who completed high school had the highest perception. Both expectations and perceptions were scored low in urban areas. The quality gap or the expectation-perception gap is not significantly different in male and female patients. The same was in different locations or different age groups of patients. But this gap was statistically significant in patients of different ethnicity and in patients with different levels of education.

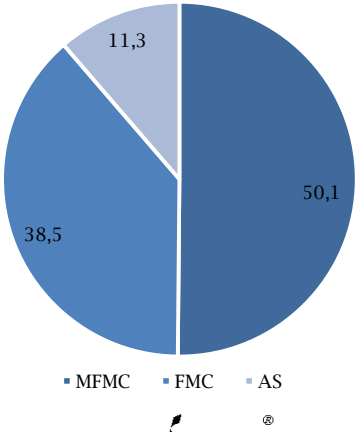
It is important to note that all data in this section are self-reported by the patients and not observed by interviewers. In the socio and demographic characteristics of the sample, there were interviewed 1,731 patients in primary health care institutions (Main Family Medical Centre (MFMC) and Family Medical Centre (FMC)) of 29 municipalities out of 38 ones in Kosovo. There was an average of 60 interviews per municipality, with the highest number of respondents in Pristina and Prizren (n = 200 in each of them) and with the lowest number of interviews in Noveberd (n = 15) (Table 13). Figure 1 shows the distribution of the interviews by municipalities, where 11.55% of respondents belong to the primary health care centers in Pristina and Prizren; 8.78% of those in Ferizaj; 8.66% in Gjakova, 8.08% in Peja, and 5.78% in Peja and Mitrovica.

Figure 1. Distribution of the sample for each municipality



The socio-demographic analysis of the data showed that the respondents were mostly males (58.1%), living in urban areas (80.4%), aged 25–44 years old (38%); they were married (67.2%), and of Albanian ethnicity (95.6%). They were mostly employed in the private sector (20.2%); have completed high school education (39%) and university (39.1%). Only 10.3% of them declared that they were receiving some social or economic aid. Half of the interviews were conducted in MFMC (50.1%), 38.5% of them were conducted in FMC, and the other 11.3% in ambulance services (AS).

Figure 2. Distribution of the sample for each type of facility



4.1. Assessment of expectations

After the assessment of the five dimensions of expectations, it resulted that the Empathy dimension scored high (5.97), while the Reliability (5.86) and the Tangible (5.87) scored low. Women scored higher than men in all dimensions of expectations. Also, the patients aged 18–24 years old, the Albanian ones who had completed university scored high. The lowest scores in all five dimensions of expectations were rated by male patients, other ethnicities-non Serb, and who had another level of education (Tables 6, 7, 8, 9, and 10).

Table 1. Descriptive analysis of expectation dimensions of the sample and for each facility

Dimensions	*Expectations (Mean, SD)*	*Expectations MFMC*	*Expectations FMC*	*Expectations AS*
Tangible	5.87 (1.31)	5.90	5.85	5.85
Reliability	5.86 (1.25)	5.88	5.86	5.82
Responsiveness	5.89 (1.23)	5.90	5.87	5.89
Assurance	5.90 (1.22)	5.90	5.90	5.92
Empathy	5.97 (1.21)	5.97	5.96	6.01

Analysed by each facility, the Tangible, Reliability, and Responsiveness dimensions of the expectations scored higher in MFMC, while the Assurance and Empathy dimensions scored higher in AS (Table 1).

In regard to the patients' expectations, Table 2 shows that the most rated declarations from the Tangible dimension of the expectations were *"The personnel should be well dressed and appear neat"* (49.2%) and *"They should have available essentials drugs and medical products"* (48.4%). In the Tangible dimension, the expectations were rated higher by women (5.97), located in urban areas (5.88), aged 18–24 years old (5.99), of Albanian ethnicity (5.91), and who had completed the university (5.95). While the lowest levels were rated by male patients (5.81), located in rural areas (5.83), aged 45–64 years old (5.83), of another non-Serb ethnicity (4.99), and who had another level of education (5.22) (Tables 6, 7, 8, 9, and 10). While, the most rated declarations from the Reliability dimension of the expectations were *"They should provide their services at the time they promise to do so and a level of service same at all times of day and for all members of staff"* (49%) and *"The personnel and PHC should have a good reputation"* (45.1%). In Reliability, the expectations were rated higher by women (5.96), located in rural areas (5.87), aged 18–24 years old (5.98), of Albanian ethnicity (5.90), and who had completed the university (5.91). While the lowest levels were rated by male patients (5.82), located in urban areas (5.85), aged 45–64 years old (5.8), of another non-Serb ethnicity (4.9), and who had another level of education (5.14) (Tables 6, 7, 8, 9, and 10).

In terms of patients' expectations, the most rated declarations from the Responsiveness dimension of the expectations were *"This PHC is expected to be conveniently located"* (51.1%), and *"This PHC should treat patients' situations with care and seriousness"* (47.5%). In Responsiveness, the expectations were rated higher by women (6.03), located in rural areas (5.92), aged 18–24 years old (5.97), of Albanian ethnicity (5.93), and who had completed the university (5.93). While the lowest levels were rated by male patients (5.92), located in urban areas (5.87), aged 45–64 years old (5.84), of another non-Serb ethnicity (4.76), and who had another level of education (5.09) (Tables 4, 5, 6, 7, and 8).

Based on results (Table 2), the most rated declarations from the Assurance dimension of the expectations were *"They should keep patient records accurately"* (52.7%), and *"They should use the equipment quickly and skilfully"* (48.7%). In Assurance, the expectations were rated higher by women (4.75), located in rural areas (5.94), aged 18–24 years old (6.04), of Albanian ethnicity (5.95), and who had completed the university (5.99). While the lowest levels were rated by male patients (4.69), located in urban areas (5.89), aged more than 65 years old (5.81), of another non-Serb ethnicity (4.58), and who had another level of education (5.03) (Tables 6, 7, 8, 9, and 10). From Table 2, it is shown that the most rated declarations of the Empathy dimension of the expectations were *"It is expected they will listen to patient problems and demonstrate understanding and concern"* (53.8%), and *"They should be expected to avoid using medical jargon when speaking with the patients"* (51.8%). In this dimension, the expectations were rated higher by women (4.68), located in rural areas (6.01), aged 18–24 years old (6.07), of Albanian ethnicity (6.01), and who had completed the university (6.04). While the lowest levels were rated by male patients (4.58), located in urban areas (5.95), aged more than 65 years old (5.86), of another non-Serb ethnicity (4.8), and who had another level of education (5.38) (Tables 6, 7, 8, 9, and 10).

Table 2. Results for expectations by quality dimension

Tangible dimension	***1***	***2***	***3***	***4***	***5***	***6***	***7***
1. They should have up-to-date and functional essential medical equipment and supplies.	36 2.1%	52 3%	85 4.9%	154 8.9%	208 12%	431 24.9%	765 44.2%
2. They should have available essentials drugs and medical products.	38 2.2%	64 3.7%	65 3.8%	112 6.5%	216 12.5%	398 23%	838 48.4%
3. Their physical facilities should be visually appealing and clean.	24 1.4%	60 3.5%	62 3.6%	120 6.9%	236 13.6%	397 22.9%	828 47.8%
4. The personnel should be well dressed and appear neat.	11 0.6%	46 2.7%	70 4%	107 6.2%	223 12.9%	417 24.1%	853 49.2%
Reliability dimension	***1***	***2***	***3***	***4***	***5***	***6***	***7***
5. They should be dependable.	19 1.1%	41 2.4%	71 4.1%	141 8.1%	314 18.1%	426 24.6%	715 41.3%
6. The personnel and PHC should have a good reputation.	13 0.8%	52 3.0%	69 4.0%	130 7.5%	303 17.5%	380 21.9%	781 45.1%
7. They should provide their services at the time they promise to do so and a level of service same at all times of day and for all members of staff.	20 1.2%	50 2.9%	66 3.8%	119 6.9%	224 13.6%	400 23.1%	849 49%
8. They should provide accurate and visible information on the services they offer in this PHC.	22 1.3%	37 2.1%	59 4%	141 8.1%	264 15.2%	442 25.5%	762 44%
Responsiveness dimension	***1***	***2***	***3***	***4***	***5***	***6***	***7***
9. They should respond to patient requests promptly.	40 2.3%	56 3.2%	54 3.1%	104 6%	297 17.1%	520 30%	657 37.9%
10. They should always be willing to help patients.	32 1.8%	55 3.2%	48 2.8%	122 7%	238 13.7%	433 25%	800 46.2%
11. This PHC should treat patients' situations with care and seriousness.	13 0.8%	52 3%	62 3.6%	111 6.4%	268 15.5%	399 23%	823 47.5%
12. This PHC should be expected to have operating hours convenient to all patients.	22 1.3%	46 2.7%	77 4.4%	100 5.8%	248 14.3%	432 24.9%	802 46.3%
13. This PHC is expected to be conveniently located.	15 0.9%	25 1.4%	74 4.3%	141 8.1%	235 13.6%	350 20.2%	885 51.1%
Assurance dimension	***1***	***2***	***3***	***4***	***5***	***6***	***7***
14. Patients should be able to trust personnel of this PHC.	21 1.2%	43 2.5%	56 3.2%	129 7.4%	346 20%	452 26.1%	679 39.2%
15. All provided materials in this PHC should be appropriate and up to date.	25 1.4%	43 2.5%	63 3.6%	124 7.2%	288 16.6%	390 22.5%	792 45.8%
16. They should use the equipment quickly and skillfully.	21 1.2%	38 2.2%	72 4.2%	116 6.7%	245 14.1%	391 22.6%	844 48.7%
17. They should keep patient records accurately.	19 1.1%	44 2.5%	60 3.5%	101 5.8%	227 13.1%	362 20.9%	913 52.7%
Empathy dimension	***1***	***2***	***3***	***4***	***5***	***6***	***7***
18. This PHC should be expected to give patients individual attention.	22 1.3%	37 2.1%	46 2.7%	111 6.4%	263 15.2%	440 25.4%	807 46.6%
19. It is expected they will listen to patient problems and demonstrate understanding and concern.	23 1.3%	31 1.8%	56 3.2%	101 5.8%	232 13.4%	353 20.4%	931 53.8%
20. 20. They should show politeness, respect, consideration and friendliness.	21 1.2%	49 2.8%	73 4.2%	117 6.8%	270 15.6%	400 23.1%	798 46.1%
21. They should explain clearly the various options available to a particular patient problem.	15 0.9%	54 3.1%	54 3.1%	104 6%	219 12.7%	505 29.3%	775 44.9%
22. They should be expected to avoid using medical jargon when speaking with the patients.	17 1%	36 2.1%	65 3.8%	88 5.1%	224 13%	402 23.3%	893 51.8%

Note: 1 = "Strongly disagree"; 2 = "Disagree"; 3 = "Slightly disagree"; 4 = "Neutral"; 5 = "Slightly agree"; 6 = "Agree"; 7 = "Strongly agree".

4.2. Assessment of perceptions

After the assessment of the five dimensions of perceptions, it resulted that the Empathy dimension scored high (4.9), while the Tangible dimension (4.36) scored low (Table 3). Women scored higher than men in all dimensions of expectations. The patients located in rural areas scored high too. The lowest scores in all five dimensions of expectations were rated by male patients, located in urban areas and who had another level of education (Tables 6, 7, 8, 9, and 10).

Table 3. Descriptive perceptions' dimensions of the sample and for each facility

Dimensions	***Perceptions (Mean, SD)***	***Perceptions MFMC***	***Perceptions FMC***	***Perceptions AS***
Tanglibles	4.36 (1.36)	4.35	4.41	4.26
Reliability	4.72 (1.47)	4.72	4.71	4.77
Responsiveness	4.77 (1.47)	4.76	4.77	4.78
Assurance	4.63 (1.44)	4.62	4.66	4.55
Empathy	4.90 (1.55)	4.92	4.88	4.91

Analysed by each facility, the Tangible and the Assurance dimensions of the perceptions scored higher in FMC, while the Reliability and the Responsiveness dimensions scored higher in AS. The Empathy dimension of perceptions scored higher in MFMC.

Table 4. Results for perceptions by quality dimension

Tangible dimension	***1***	***2***	***3***	***4***	***5***	***6***	***7***
1. They have up-to-date and functional essential medical equipment and supplies.	75 4.3%	297 17.2%	261 15.1%	312 18%	326 18.8%	280 16.2%	176 10.2%
2. They have available essentials drugs and medical products.	171 9.9%	292 16.9%	333 19.3%	389 22.5%	245 14.2%	152 8.8%	146 8.4%
3. Their physical facilities are visually appealing and clean.	59 3.4%	116 6.7%	301 17.4%	370 21.4%	377 21.8%	255 14.7%	252 14.5%
4. The personnel is well dressed and appear neat.	43 2.5%	135 7.8%	208 12%	244 14.1%	350 20.3%	290 16.8%	455 26.4%
Reliability dimension	***1***	***2***	***3***	***4***	***5***	***6***	***7***
5. This PHC is dependable.	65 3.8%	135 7.8%	189 10.9%	315 18.2%	487 28.2%	283 16.4%	255 14.7%
6. The personnel and this PHC have a good reputation.	65 3.8%	125 7.2%	230 13.3%	318 18.4%	386 22.3%	315 18.2%	290 16.8%
7. They provide their services at the time they promise to do so and a level of service same at all times of day and for all members of staff.	52 3%	142 8.2%	216 12.5%	320 18.5%	426 24.6%	290 16.8%	283 16.4%
8. This PHC provides accurate and visible information on the services they offer.	55 3.2%	133 7.7%	195 11.3%	279 16.1%	425 24.5%	311 18%	330 19.1%
Responsiveness dimension	***1***	***2***	***3***	***4***	***5***	***6***	***7***
9. They respond to patient requests promptly.	81 4.7%	152 8.8%	192 11.1%	331 19.1%	441 25.5%	309 17.8%	223 12.9%
10. They are always willing to help patients.	58 3.3%	138 8%	222 12.8%	289 16.7%	377 21.8%	305 17.6%	341 19.7%
11. This PHC treats patients' situations with care and seriousness.	30 1.7%	169 9.8%	215 12.4%	280 16.2%	437 25.2%	330 19.1%	270 15.6%
12. This PHC has operating hours convenient to all patients.	80 4.6%	168 9.7%	190 11%	297 17.1%	411 23.7%	317 18.3%	263 15.2%
13. This PHC is conveniently located.	82 4.7%	92 5.3%	165 9.5%	219 12.6%	311 18%	299 17.3%	559 32.3%
Assurance dimension	***1***	***2***	***3***	***4***	***5***	***6***	***7***
14. Patients trust personnel of this PHC.	52 3%	150 8.7%	197 11.4%	303 17.5%	411 23.7%	349 20.2%	268 15.5%
15. All provided materials in this PHC are appropriate and up to date.	90 5.2%	212 1.2%	356 20.6%	305 17.6%	341 19.7%	248 14.3%	178 10.3%
16. They use the equipment quickly and skillfully.	62 3.6%	166 9.6%	253 14.6%	284 16.4%	376 21.7%	273 15.8%	312 18%
17. They keep patient records accurately.	54 3.1%	133 7.7%	190 11%	261 15.1%	339 19.6%	324 18.7%	429 24.8%
Empathy dimension	***1***	***2***	***3***	***4***	***5***	***6***	***7***
18. This PHC gives patients individual attention.	56 3.2%	139 8%	183 10.6%	271 15.6%	417 24.1%	328 19%	333 19.3%
19. They listen to patient problems and demonstrate understanding and concern.	63 3.6%	137 7.9%	190 11%	293 16.9%	372 21.5%	346 20%	326 18.9%
20. They show politeness, respect, consideration and friendliness.	68 3.9%	122 7%	181 10.5%	296 17.1%	357 20.6%	299 17.3%	405 23.4%
21. They explain clearly the various options available to a particular patient problem.	55 3.2%	115 6.7%	193 11.1%	235 13.6%	407 23.5%	289 16.7%	435 25.2%
22. They avoid using medical jargon when speaking with the patients.	71 4.1%	111 6.4%	157 9.1%	251 14.5%	400 23.1%	318 18.4%	421 24.3%

Note: 1 = "Strongly disagree"; 2 = "Disagree"; 3 = "Slightly disagree"; 4 = "Neutral"; 5 = "Slightly agree"; 6 = "Agree"; 7 = "Strongly agree".

In regard to the patients' perceptions (Table 4), the most rated declaration from the Empathy dimension of the perception was *"The personnel is well dressed and appear neat"* (26.4%). In this dimension, the perceptions were rated higher by women (4.44), located in rural areas (4.4), aged more than 65 years old (4.48), of Serb ethnicity (4.52), and who had completed high school (4.51). While the lowest levels were rated by male patients (4.35), located in urban areas (4.35), aged 45–64 years old (4.29), of another non-Serb ethnicity (4.12), and who had another level of education (3.92) (Tables 6, 7, 8, 9, and 10). The most rated declaration of the Reliability dimension of the perception was *"This PHC is dependable"* (28.2%), at a moderate value of 5 on the Likert scale. Also, in the Reliability dimension, the perceptions were rated higher by women (4.76), located in rural areas (4.93), aged more than 65 years old (4.75), of Albanian ethnicity (4.72), and who had completed the university (4.61). While the lowest levels were rated by male patients (4.69), located in urban areas (4.67), aged 45–64 years old (4.69), of another non-Serb ethnicity (4.51), and who had another level of education (4.09) (Tables 6, 7, 8, 9, and 10).

The most rated declaration from the Responsiveness dimension of the perception was *"This PHC is conveniently located"* (32.3%). In this dimension, the perceptions were rated higher by women (4.84), located in rural areas (4.95), aged 18–24 years old (4.84), of Albanian ethnicity (4.52), and who had completed primary school (4.91). While the lowest levels were rated by male patients (4.74), located in urban areas (4.72), aged 45–64 years old (4.7), of another non-Serb ethnicity (4.48), and who had another level of education (3.93) (Tables 6, 7, 8, 9, and 10). In terms of patients' perceptions, (Table 4), the most rated declaration from

the Assurance dimension of the perception was *"They keep patient records accurately"* (24.8%). In the Assurance dimension, the perceptions were rated higher by women (4.68), located in rural areas (4.73), aged more than 65 years old (4.74), of Albanian ethnicity (4.63), and who had completed high school (4.74). While the lowest levels were rated by male patients (4.59), located in urban areas (4.6), aged 45–64 years old (4.52), of another non-Serb ethnicity (4.47), and who had another level of education (3.86) (Tables 6, 7, 8, 9, and 10). Regarding the Empathy dimension, the most rated declaration of the perception was *"They explain clearly the various options available to a particular patient problem"* (25.2%). In this dimension, the perceptions were rated higher by women (4.97), located in rural areas (5.05), aged more than 65 years old (4.94), of Albanian ethnicity (4.9), and who had completed high school (5.06). While the lowest levels were rated by male patients (4.85), located in urban areas (4.86), aged 45–64 years old (4.8), of Serb ethnicity (4.7), and who had another level of education (4.36) (Tables 6, 7, 8, 9, and 10).

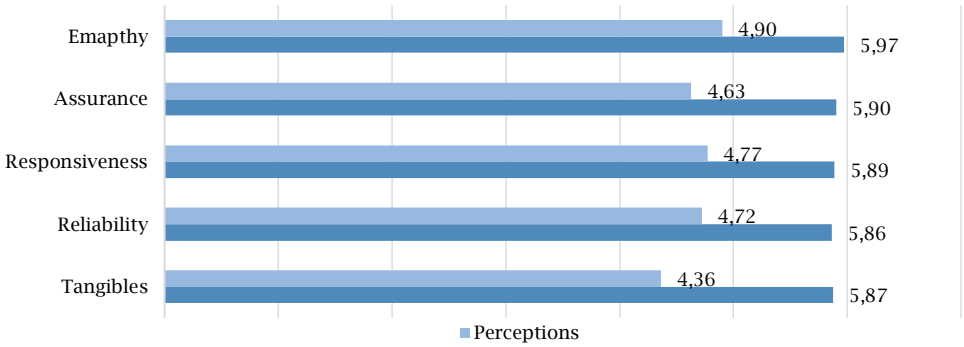
4.3. Discussion

Based on the above results of measuring the perception of quality management of primary healthcare services through the SERVQUAL model, the overall assessment of expectations and perceptions of the relevant services in primary healthcare centres in Kosovo are as follows. Expectations scored higher than perceptions and this gap is important across all dimensions. The Tangible dimension presented the higher gap, followed by the Responsiveness dimension. The Empathy dimension produced the lowest gap (Table 5).

Table 5. Means of expectation and perception dimensions and the quality gap

Dimensions	*Expectations (Mean, SD)*	*Perceptions (Mean, SD)*	*Quality gap (Mean, SD)*
Tangible	5.87 (1.31)	4.36 (1.36)	-1.52 (1.74)
Reliability	5.86 (1.25)	4.72 (1.47)	-1.14 (1.58)
Responsiveness	5.89 (1.23)	4.77 (1.47)	-1.12 (1.53)
Assurance	5.90 (1.22)	4.63 (1.44)	-1.27 (1.55)
Empathy	5.97 (1.21)	4.90 (1.55)	-1.07 (1.59)

Figure 3. Comparing means dimensions of expectations and perceptions



Assessment of expectations and perceptions pertaining to gender

The expectations were rated higher by women patients (mean = 5.97, SD = 1.17), as well as the perceptions (mean = 4.73, SD = 1.33). There were not significant differences between participants of different genders in terms of the perceptions of the quality of the primary healthcare centres (Table 6).

Table 6. Differences between males and females

	Gender	*N*	*Mean (SD)*	*P-value*
Expectations	Male	1006	5.84 (1.16)	0.017*
	Female	721	5.97 (1.17)	
	Total		5.89 (1.16)	
Perceptions	Male	1006	4.63 (1.35)	0.144
	Female	721	4.73 (1.29)	
	Total		4.68 (1.33)	

*Note: * flags the level of significance.*

Assessment of expectations and perceptions pertaining to age groups

The expectations scored higher by young patients, aged 18–24 years old (mean = 5.97, SD = 1.17), while the highest level of perception was produced by patients aged more than 65 years old (mean = 4.73, SD = 1.33). There were no significant differences between participants of different age groups in terms of both, the expectations and the perceptions of the quality of the primary healthcare centres (Table 7).

Table 7. Differences between age groups

	Age group	*N*	*Mean (SD)*	*P-value*
Expectations	18–24 years old	361	6.01 (1.05)	0.225
	25–44 years old	659	5.87 (1.23)	
	45–64 years old	487	5.86 (1.16)	
	More than 65 years old	221	5.84 (1.12)	
	Total		5.89 (1.16)	
Perceptions	18–24 years old	361	4.71 (1.37)	0.541
	25–44 years old	659	4.67 (1.34)	
	45–64 years old	487	4.61 (1.31)	
	More than 65 years old	221	4.73 (1.20)	
	Total		4.67 (1.32)	

Assessment of expectations and perceptions pertaining to ethnicity

The expectations scored higher by Albanian patients, as well as their perceptions. In terms of all five dimensions, the comparison based on ethnicity resulted in higher scores from the Albanian patients in all five dimensions of expectations, while the perception dimensions scored differently (Table 8).

There were significant differences between participants of different ethnicities in terms of the expectations of the quality of the primary healthcare centres (Table 8), but there were no significant differences between participants of different ethnicities in terms of perceptions.

Assessment of expectations and perceptions pertaining to the education level

The expectations scored higher in patients who had completed the university, while the perceptions scored higher in patients who had completed high school. There were significant differences between participants of different education levels in terms of the expectations of the quality of the primary healthcare centres (Table 9), as well as in terms of their perception.

Assessment of expectations and perceptions pertaining to the location

The expectations scored lower by patients who lived in urban areas, as well as their perceptions. There were significant differences between participants of different education levels in terms of the expectations of the quality of the primary healthcare centres (Table 10), as well as in terms of their perception. There were no significant differences between participants of different locations in terms of the expectations of the quality of the primary healthcare centres (Table 10), as well as in terms of their perception.

Table 8. Differences between ethnic groups

	Ethnicity	*N*	*Mean (SD)*	*P-value*
Expectations	Albanian	1655	5.93 (1.12)	0.000*
	Serb	16	5.17 (1.54)	
	Other — non-Serb	50	4.80 (1.85)	
	Total		5.89 (1.16)	
Perceptions	Albanian	1655	4.68 (1.32)	0.567
	Serb	16	4.56 (1.21)	
	Other — non-Serb	50	4.47 (1.53)	
	Total		4.67 (1.32)	

*Note: * flags the level of significance.*

Table 9. Differences between education levels

	Education	*N*	*Mean (SD)*	*P-value*
Expectations	Completed primary school	329	5.82 (1.20)	0.000*
	Completed high school	678	5.90 (1.16)	
	Completed college/University	675	5.96 (1.07)	
	Other	40	5.17 (1.71)	
	Total		5.89 (1.16)	
Perceptions	Completed primary school	329	4.76 (1.17)	0.000*
	Completed high school	678	4.78 (1.23)	
	Completed college/University	675	4.56 (1.47)	
	Other	40	4.03 (1.18)	
	Total	1731	4.67 (1.32)	

*Note: * flags the level of significance.*

Table 10. Differences between locations

	Location	*N*	*Mean (SD)*	*P-value*
Expectations	Urban	1391	5.89 (1.17)	0.65
	Rural	339	5.91 (1.11)	
	Total		5.89 (1.16)	
Perceptions	Urban	1391	4.64 (1.37)	0.087
	Rural	339	4.81 (1.11)	
	Total		4.67 (1.32)	

Assessment of expectations and perceptions pertaining to types of facilities

Higher expectations were presented by the interviewees in MFMC, while higher perceptions although there were no big differences were presented in FMC. There were no significant differences between participants of different facilities in terms of the expectations of the quality of the primary healthcare centres, as well as in terms of their perception (Table 11).

Expectations and perceptions' gap in the quality of the healthcare services

ANOVA analysis showed that the expectation–perception gap is statistically significant. So, there is a quality gap in all five dimensions (Table 12).

Table 11. Differences between facilities

	Facility	*N*	*Mean (SD)*	*P-value*
Expectations	MFMC	868	5.91 (1.16)	0.919
	FMC	667	5.88 (1.15)	
	AS	196	5.90 (1.26)	
	Total		5.90 (1.17)	
Perceptions	MFMC	868	4.67 (1.32)	0.947
	FMC	667	4.69 (1.39)	
	AS	196	4.65 (1.16)	
	Total		4.68 (1.33)	

Table 12. Comparing gap means of expectations and perceptions' dimensions

Expectations–Perceptions	*Paired differences*					*t*	*df*	*Sig. (2-tailed)*
	Mean	*Std. deviation*	*Std. error mean*	*95% confidence interval of the difference*				
				Lower	*Upper*			
Tangibles	1.51	1.73	0.041	1.42	1.59	36.1	1729	0.000
Reliability	1.14	1.57	0.037	1.06	1.21	30.1	1730	0.000
Responsiveness	1.11	1.52	0.036	1.04	1.18	30.8	1728	0.000
Assurance	1.27	1.54	0.037	1.2	1.34	34.2	1726	0.000
Empathy	1.068	1.58	0.038	0.99	1.14	28	1728	0.000

*Note: * Confidence interval: mean value ± quoted value for a confidence level of 95%.*

The analysis showed that there were no significant differences between expectations and perceptions of the patients in terms of gender. The quality gap was not statistically different between male and female patients. The same resulted also with patients from different locations or different age groups. The quality gap is not statistically different in terms of ethnicity and education level.

Quality gap assessment pertaining to municipalities

Table 13 represents the average values of expectations and perceptions of patients in different municipalities, as well as the quality gap for each of them.

Table 13. Quality gap in different municipalities (Part 1)

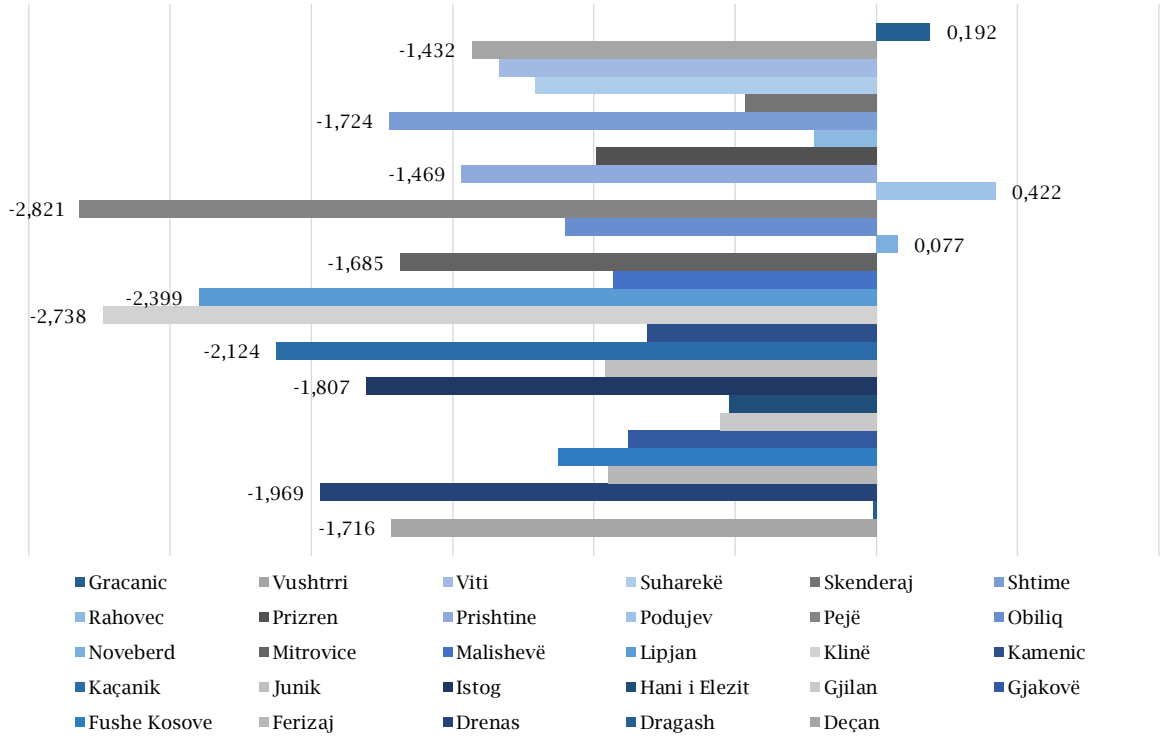
Municipality	*N*	*Mean*	*Patients' reflection*	*Quality gap*
Deçan	20	5.52	Expect	-1.716
		3.81	Percept	
Dragash	30	5.97	Expect	-0.013
		5.96	Percept	
Drenas	30	6.86	Expect	-1.969
		4.90	Percept	
Ferizaj	152	6.51	Expect	-0.952
		5.55	Percept	
FusheKosove	31	6.04	Expect	-1.126
		4.92	Percept	
Gjakovë	150	4.77	Expect	-0.880
		3.89	Percept	
Gjilan	100	5.02	Expect	-0.551
		4.47	Percept	
Hani I Elezit	25	6.65	Expect	-0.523
		6.12	Percept	
Istog	20	5.55	Expect	-1.807
		3.74	Percept	
Junik	20	5.48	Expect	-0.959
		4.52	Percept	
Kaçanik	24	6.81	Expect	-2.124
		4.68	Percept	
Kamenic	35	5.45	Expect	-0.810
		4.64	Percept	
Klinë	20	5.83	Expect	-2.738
		3.09	Percept	

Table 13. Quality gap in different municipalities (Part 2)

Municipality	*N*	*Mean*	*Patients' reflection*	*Quality gap*
Lipjan	41	6.69	Expect	-2.399
		4.30	Percept	
Malishevë	25	6.01	Expect	-0.934
		5.08	Percept	
Mitrovice	100	6.57	Expect	-1.685
		4.88	Percept	
Noveberd	15	5.12	Expect	0.077
		5.20	Percept	
Obiliq	25	5.71	Expect	-1.100
		4.61	Percept	
Pejë	140	5.95	Expect	-2.821
		3.13	Percept	
Podujev	35	3.39	Expect	0.422
		3.82	Percept	
Prishtine	200	6.79	Expect	-1.469
		5.32	Percept	
Prizren	200	5.98	Expect	-0.992
		4.99	Percept	
Rahovec	50	4.58	Expect	-0.221
		4.36	Percept	
Shtime	39	6.66	Expect	-1.724
		4.94	Percept	
Skenderaj	50	6.05	Expect	-0.463
		5.59	Percept	
Suharekë	25	5.91	Expect	-1.208
		4.70	Percept	
Viti	50	6.81	Expect	-1.337
		5.48	Percept	
Vushtrri	50	5.63	Expect	-1.432
		4.20	Percept	
Gracanice	29	3.39	Expect	0.192
		3.59	Percept	

The quality gap is larger in the municipalities of Peje (-2.82), Klinë (-2.74), Lipjan (-2.39), Kacanik (-2.13). A positive value of this quality gap means that perception of the healthcare service exceeded that expectations for this service (Table 13). There are also statistical differences in the quality gap between municipalities.

Figure 4. Quality gap in different municipalities



Quality gap assessment pertaining to types of facilities

The quality gap resulted in larger in ambulance of family medicine (AFM) (-1.25) and smaller in centre for familly medicine (CFM) (-1.20). When analyzing every dimension, the lower quality gap resulted in the Empathy dimension in MFMC and FMC and in the Reliability dimension in AC. While the higher gap resulted in all three facilities in the Tangible dimension (Table 14).

Table 14. Quality gap in five dimensions of different facilities

Facilities	*MFMC*			*FMC*			*AS*		
Dimensions	*Expectations*	*Perceptions*	*Quality gap*	*Expectations*	*Perceptions*	*Quality gap*	*Expectations*	*Perceptions*	*Quality gap*
Tangibles	5.90	4.35	-1.55	5.85	4.41	-1.44	5.85	4.26	-1.60
Reliability	5.88	4.72	-1.16	5.86	4.71	-1.15	5.82	4.77	-1.05
Responsiveness	5.90	4.76	-1.14	5.87	4.77	-1.09	5.89	4.78	-1.11
Assurance	5.90	4.62	-1.28	5.90	4.66	-1.24	5.92	4.55	-1.38
Empathy	5.97	4.92	-1.05	5.96	4.88	-1.08	6.01	4.91	-1.10

Table 15. Quality gap in different facilities

Facility	*N*	*Mean*	*Patients' reflection*	*Quality gap*
MFMC	868	5.91	Expect	-1.24
		4.67	Percept	
FMC	667	5.88	Expect	-1.20
		4.69	Percept	
AS	196	5.90	Expect	-1.25
		4.65	Percept	

5. CONCLUSION

A patient-centered approach in PHC in Kosovo should consider the expectations and perceptions of patients, as it is difficult to identify and prioritize improvements required in healthcare service and to ensure that patient needs, and expectations are met. By respecting people's expectations, health care services are able to preserve public trust in them and play a vital role in treating the patient.

The national survey provided important findings on the perception of the quality of services at the PHC level. The perception of the quality of services at the PHC level showed that patients have high expectations toward the healthcare services PHC in Kosovo. Expectations serve as standards with which perceptions are compared, and the difference between them produces a gap. Our analysis showed that the Tangible dimension produced the greatest gap, while the Empathy dimension produced the smallest gap. The findings from this analysis will help to improve the service quality in primary health care institutions in Kosovo. Female patients had higher expectations than men, the same was with perceptions too. Young patients (18–24 years old) had also higher expectations toward the healthcare services in PHC in Kosovo, while the patients of more than 65 years old had higher perceptions. Albanian patients had higher scores on both, expectations and perceptions too. While the patients who had completed the university had a higher level of expectations, those who completed high school had the highest perception. Both expectations and perceptions were scored low in urban areas.

The quality gap or the expectation-perception gap is not significantly different in male and female patients. The same as in different locations or different age groups of patients. But this gap was statistically significant in patients of different ethnicity and in patients with different levels of education.

A patient-centered approach in PHC in Kosovo should consider the expectations and perceptions of patients. There is always a difference between them or a gap. The negative gap indicates that patient expectations for the service were not met and the patient is not satisfied with the service. In a positive gap, the service exceeded the expectations and the patient was satisfied. Therefore, it is very important to evaluate both perceptions and expectations, as it is difficult to identify and prioritize improvements required in healthcare service to ensure that patient needs and expectations are met. By respecting people's expectations, health care services are able to preserve public trust in them and play a vital role in treating the patient. It is also recommended that in order to improve the quality of health care, the important focus should be addressed to: a) the education of the population, through information and awareness; b) the quality standards in PHC in Kosovo, and c) the establishment of a mechanism to raise public awareness in case of complaints with the service.

There is an imperative need to begin the process of accreditation of the PHC, and to implement it, in order the patients' rights will be provided. There is a continuous need in educating and training the operative and management staff of PHC in order to improve the quality of services; there is also needed a close cooperation between PHC, health care professionals and other professionals of social services in order to improve the quality of services in PHC in Kosovo.

This study, in terms of research methodology and scientific research results, besides serving young researchers who want to study or compare the level of quality of primary healthcare services at the national, regional, or global level, the same one can be used also by relevant local and international institutions in the context of comparability or development policy-making, with the sole purpose

of improving the quality of primary healthcare services.

As concerning limitations, like all other studies, this study had its own limitations in the context of actual situation analysis due to the lack of previous studies conducted in the field of measuring the perception of the quality of primary healthcare services at the local, national or regional level. Then the logistical issues, the issue of translation of all study instruments, and other related data in all languages, by adapting to each community living in Kosovo, etc.

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