Reframing Donabedian's Model as an Operational Maturity Framework: Evidence from the Romanian Public and Private Healthcare

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Abstract: *The relationship between operations management practices and healthcare quality is well-established in the literature, yet the conditions under which these practices can be successfully transferred across organisational contexts remain poorly understood. This paper proposes a reinterpretation of Donabedian's classic structures-processes-outcomes model as a hierarchical operational maturity framework for healthcare organisations, in which progress on higher-order dimensions is conditioned on sufficient maturity at lower-order dimensions. The framework is applied to the Romanian healthcare context, where a sharp and well-documented asymmetry between the public and private sectors provides an instructive analytical setting. Drawing on documentary analysis of public sources including ANMCS accreditation reports, Eurostat and OECD data, peer-reviewed governance assessments, and private network annual reports, the paper identifies a structural maturity gap as the primary constraint on the transferability of operational excellence tools (TQM, Lean, Six Sigma) to Romanian public hospitals. Four theoretical propositions are advanced, with implications for healthcare management practice and future empirical research.*

Key words: operations management, operational excellence, Donabedian model, healthcare quality, public-private healthcare

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1. Introduction

Healthcare quality stands as one of the most persistently debated subjects in contemporary management science - across academic literature, among clinicians and patients, and between managers of public and private hospitals alike. The role that quality management plays in health services, and the degree to which successful management practices from other sectors can be integrated into healthcare organisations, have generated a substantial and unresolved body of research. At the centre of this debate lies a fundamental and still-open question: to what extent are management practices and processes applicable across a wide range of organisations, regardless of their public or private nature?

This paper argues that the existing literature has insufficiently addressed the structural preconditions for operational excellence in healthcare. While much attention has been devoted to the tools of quality improvement - Total Quality Management, Lean, Six Sigma - considerably less has been given to the organisational conditions that must be in place before these tools can function effectively. A hospital that lacks managerial autonomy, adequate infrastructure, and integrated information systems will not benefit from Lean implementation in the same way as one that possesses these structural foundations.

To address this gap, the paper proposes a reinterpretation of Donabedian's (2003) model - the most widely used conceptual framework in healthcare quality - as a hierarchical operational maturity grid. In this reinterpretation, the three Donabedian dimensions (structures, processes, outcomes) function not merely as independent evaluation categories but as interdependent maturity levels. This theoretical contribution is then applied to the Romanian care system, which provides an unusually clear empirical setting: a well-documented, extreme asymmetry between a chronically underfunded public sector and a rapidly professionalising private sector makes the structural dimension of quality analytically visible in ways that more uniform systems would not permit.

2. Relevant literature

Two branches of management science developed historically in parallel: one inside the private domain and one inside the public domain. This conventional taxonomy has been increasingly disputed, and a more generic approach to management - one that transcends the public-private divide - has developed around it. Researchers today claim that management has universal applicability, whether in business or in the non-profit public sector. Yet one of the major unresolved problems in the management literature has been the extent to which management processes and practices are transferable across a wide range of organisations (Fottler, 1981).

The debate dominated the 1970s and 1980s, questioning whether meaningful differences exist between the ways organisations in the public and private fields are structured and managed. One perspective identified significant differences reflected in the very terminology used: 'management' described how private companies were run, while 'administration' described how public organisms were run. The former was associated with decision-making driven by efficiency and organisational growth; the latter with the implementation of governmental policies within

a legal framework, in which efficient resource use was of secondary importance (Farnham and Horton, 1996).

A convergent perspective, however, gained ground. Murray (1975) suggested that management practices for public and private organisations are convergent, as both face similar constraints and challenges. A central element of the New Public Management reform agenda (Ferlie et al., 1996) is precisely the proposition that public organisations should import leadership processes and behavioural patterns from the private sector. Yet this position was also strongly challenged. Allison (1979) argued that the idea of a significant body of management knowledge directly transferable from private to public management - in ways that would produce genuine improvements - was fundamentally mistaken. Quantitative research has discovered differences between public and private organisations in human resource management (Boyne et al., 1999), ethical issue management (Berman et al., 1994), and decision-making processes (Nutt, 2000), while qualitative studies found differences in strategic management styles (Boyne, 2002).

This argument aligns closely with contingency theory in organisational analysis, which rejects the existence of universally optimal management practices and instead emphasises the fit between organisational context and managerial structures and processes. Donaldson (2001) argues that organisational performance depends on the alignment between contextual contingencies - such as size, environment, technology, and institutional constraints - and internal organisational arrangements. From a contingency perspective, management tools and practices cannot be evaluated independently of the structural conditions within which they are deployed. Applied to healthcare operations, this implies that process-level improvement instruments such as Lean, TQM, or Six Sigma cannot be expected to generate consistent performance gains in organisations whose structural endowment is misaligned with the requirements of these tools. The reinterpretation of Donabedian's framework proposed in this paper is therefore compatible with contingency theory, insofar as it treats structural maturity as a binding condition that shapes the effectiveness of process interventions.

The conclusion that management techniques can be successfully exported from one sector to another is therefore questionable, given differences in organisational environments, goals, structures, and managerial values. Such variables represent a set of contingencies that may require substantially different management approaches in public and private organisations. Yet Voss et al. (1985), Chase and Prentis (1987), and Prasad and Babbar (2000) demonstrated that public organisations including schools and hospitals - and even international bodies such as the United Nations - can improve their operational efficiency by adopting tools and techniques developed in manufacturing systems.

The literature on quality management in healthcare adds a further dimension. Arndt and Bigelow (1995) specifically examined the fit between TQM and hospital environments, identifying structural and cultural factors that complicate implementation. Goldstein and Naor (2005) provided empirical evidence linking the publicness of an organisation to its quality management practices, finding that more public organisations exhibit systematically different quality management profiles from more private ones. This paper builds on this tradition while advancing the argument that the structural dimension - rather than sector identity per se - is the operative

constraint.

A complementary explanation is provided by institutional theory, particularly the concept of institutional isomorphism. DiMaggio and Powell (1983) argue that organisations operating within highly institutionalised fields tend to adopt formal structures and practices primarily to achieve legitimacy rather than to improve performance. In such contexts, managerial reforms may function as symbolic compliance mechanisms, decoupled from underlying operational realities. This perspective is particularly relevant to publicly funded healthcare systems, where accreditation systems and quality certification requirements may encourage ceremonial adoption of quality frameworks without the structural capacity required for their effective implementation. The Romanian accreditation regime, as discussed in this paper, can be interpreted through this lens: quality management structures exist formally, but their operational impact remains limited in the absence of managerial autonomy, financial resources, and integrated information systems. Institutional theory thus helps explain why adherence to quality standards does not automatically translate into performance improvement in structurally constrained public hospitals.

3. Landmarks in operations and quality management

The lineage of operations and quality management stretches from Adam Smith's 1776 account of the division of labour through the Industrial Revolution and into the systematic frameworks of the twentieth century. F. W. Taylor's scientific management (1911) introduced data-driven analysis of production processes; Walter Shewhart's Statistical Process Control (1920s) shifted the emphasis from post-production inspection to real-time defect prevention. After 1940, the rise of computing gave managers new analytical capabilities and accelerated the shift from quantity to quality as the primary performance criterion.

The major quality management frameworks emerged in the second half of the twentieth century. Deming, Juran, Crosby, Feigenbaum, and Ishikawa each contributed to the body of knowledge now known as Total Quality Management (TQM), centred on statistically controlled processes, total employee involvement, and continuous improvement. The Toyota Production System gave rise to Lean manufacturing, which eliminates seven categories of waste: overproduction, waiting, transport, overprocessing, excess inventory, motion, and defects. Six Sigma, developed at Motorola in the 1980s, added a rigorous statistical methodology for reducing process variation. All three frameworks share a common ambition: to improve quality and reduce costs through systematic process management. Their extension from manufacturing to service organisations, including hospitals, has been extensively documented (Voss et al., 1985; Chase and Prentis, 1987; Prasad and Babbar, 2000) and constitutes the direct lineage of this paper.

Operational performance is currently measured across five dimensions: cost, quality, availability, flexibility, and innovation. Crucially, the adoption of best practices cannot be treated as a universally applicable solution: industrial context, national culture, organisational size, and structural endowment all mediate the effectiveness of operational improvement efforts - a finding central to the argument developed in this paper.

4. Quality dimensions in healthcare: the Donabedian model

Avedis Donabedian is considered the creator of the modern quality concept in healthcare. He defined healthcare quality as 'the kind of care that will maximise the patient's wellbeing, taking into account the balance between expected gains and losses in all stages of the healthcare process' (Donabedian, 2003). The World Health Organization defines the quality of a healthcare system as the 'degree to which it achieves the implicit goals of improving health and responding to general expectations'. Healthcare quality depends on human resources as well as physical, financial, and technological resources.

Donabedian identified three fundamental dimensions of healthcare quality: structure, process, and outcome. Structure represents the relatively stable features of the healthcare provider, including buildings, equipment, staffing, and financial resources; it is the precondition for process, because without adequate structural endowment, processes cannot be systematically managed or improved. Process refers to the activities carried out within the provider-patient relationship, including clinical evaluation, treatment, communication, and support activities. Outcome refers to the change in current or future health status attributable to healthcare provided - the ultimate validator of quality, reflecting whether structural and process investments have achieved their purpose.

From these three dimensions, Donabedian derived a comprehensive set of quality attributes: efficacy, efficiency, optimisation, accessibility, legitimacy, professional competence, interpersonal relationships, continuity, safety, physical infrastructure and comfort, patient choice, and equity. Notably, Donabedian himself, in interviews with Fitzhugh Mullan (published posthumously in 2001), reflected that the model's analytical power was inseparable from human motivation: 'Systems are only mechanisms that allow reaching quality. It is the ethical dimension of individuals that becomes essential in achieving success for a system. One must love the patient and one's profession' (Mullan, 2001). This humanistic complement to a structural-analytical framework is important: the model describes necessary conditions, not sufficient ones.

Within the healthcare quality literature, Berwick's work on continuous improvement provides further support for the proposed framework. Berwick (1989) argues that quality improvement in healthcare requires not merely the application of technical methods, but the creation of organisational systems capable of learning, measurement, and sustained change. Later work emphasises that improvement initiatives fail when organisations lack the infrastructural and cultural foundations necessary to support them (Berwick, 1996). This resonates directly with the hierarchical reinterpretation of the Donabedian model advanced here: structural maturity enables learning and process control, which in turn make outcome improvement sustainable rather than episodic. Berwick's emphasis on systems thinking reinforces the view that quality tools cannot compensate for fundamental structural deficiencies but instead presuppose their existence.

A similar conclusion is reached in Øvretveit's work on quality improvement in health services, which stresses the contextual and organisational preconditions for effective quality management. Øvretveit (1992; 2009) highlights that successful quality improvement depends on leadership capacity, information systems, resource availability, and organisational stability, factors that correspond closely to the structural dimension of Donabedian's framework. Quality

methods are described not as standalone solutions, but as components of broader organisational systems. This perspective supports the argument developed in this paper that process-level interventions cannot substitute for structural reform. In healthcare systems characterised by constrained resources and politicised governance, the impact of quality improvement programmes is therefore expected to remain limited unless accompanied by changes at the structural level.

5. Theoretical framework: Donabedian as an operational maturity grid

The theoretical contribution of this paper lies in the reinterpretation of Donabedian's model - originally conceived as an evaluative framework for healthcare quality - as a hierarchical grid for assessing and guiding operational maturity in healthcare organisations. The proposal is not merely terminological. It argues that the three dimensions function as interdependent levels in which progress on higher-order dimensions is conditioned on sufficient maturity at lower-order dimensions.

In the original Donabedian model, structures, processes, and outcomes are related but essentially parallel evaluation categories. The contribution here is to make their dependency relationship explicit and directional: adequate structural endowment (D1) is a necessary precondition for effective process management (D2), and reliable outcome improvement (D3) follows from, and cannot systematically precede, process excellence. The instruments of operational excellence - TQM, Lean, Six Sigma, PDCA - are fundamentally process-level tools (D2). Their documented failure when deployed in structurally deficient organisations is not a failure of the tools themselves, but a predictable consequence of deploying D2 interventions in organisations that have not achieved D1 maturity. The framework provides a diagnostic logic: before committing to process-level improvement programmes, organisations should assess their structural maturity. Where structural deficits are severe, investment in process tools is likely to produce marginal returns unless accompanied by parallel structural reform.

This argument also has a normative implication for policy. When public health systems attempt to improve quality outcomes through accreditation mandates and quality certification programmes - without addressing the underlying structural deficit - the framework predicts that improvements will be limited and unstable. The Romanian case, examined in the following section, provides a particularly clear illustration of this dynamic.

While Donabedian's structure–process–outcome framework is sometimes criticised for implying a linear and simplified view of quality production, this paper does not treat the model as a mechanistic or predictive device. Instead, it draws on Donabedian's original emphasis on necessary rather than sufficient conditions to reinterpret the framework as a diagnostic logic of organisational maturity. The proposed hierarchical reading does not assume deterministic causality between structures, processes, and outcomes; rather, it foregrounds structural adequacy as an enabling condition for process-level interventions to function systematically and for outcome improvements to become reliable rather than episodic. In this sense, the model is used analytically, not normatively: it serves to identify binding organisational constraints on quality improvement, not to prescribe a universal sequence of reform. This interpretation is consistent with both

Donabedian's later reflections on the human and ethical dimensions of quality and contemporary operations management research on contextual contingency, which shows that identical process tools produce divergent results depending on underlying organisational endowments.

6. Application to the Romanian healthcare context

The Romanian healthcare system provides an instructive setting for applying the proposed framework. It is characterised by a sharp and well-documented asymmetry between a chronically underfunded public sector and a rapidly professionalising private sector - a contrast that makes the structural dimension of Donabedian's model analytically visible in ways that more uniform systems would not permit. This section draws on documentary evidence from publicly available sources: ANMCS reports, Eurostat and OECD data, peer-reviewed governance assessments, and private network annual reports. No primary data collection was conducted; the analysis is documentary in nature and serves as illustrative evidence for the theoretical propositions in Section 7.

6.1 Comparative analysis: the Donabedian maturity framework applied

Table 1 presents the framework applied across the three Donabedian dimensions, comparing public hospitals and private healthcare networks in Romania.

Table 1: Donabedian Operational Maturity Framework - Romanian public versus private healthcare

Dimension	Indicator	Public hospitals (Romania)	Private networks (Romania)
D1 Structures	Funding and physical infrastructure	5.8% of GDP - lowest in the EU; per capita spending EUR 1,800 vs. EU average EUR 3,832 (European Commission/ OECD, 2025). Of 554 public hospitals in 2023, only 4 were built after 1989; most buildings predate 1980 (Statista, 2025).	Continuous investment. MedLife and Regina Maria deployed over EUR 100 million in infrastructure (2019-2024). Modern facilities with advanced imaging, robotic surgery and integrated IT platforms (MedLife, 2024).
	Managerial autonomy	Severely constrained. Hospital managers are politically appointed and subject to replacement upon government changes. Governance studies confirm systematic misalignment between responsibility and decision-making authority (Duran et al., 2019).	High autonomy. Professional management teams operate under market-driven KPIs with full strategic, financial and operational independence, accountable to boards rather than political authorities.
	IT and information systems	Fragmented. Inconsistent reporting formats across hospitals; limited analytical capability; digital health tool use below EU average (European Commission/ OECD, 2025; Duran et al., 2019).	Integrated ERP and HIS systems. ISO 15189 in all MedLife laboratories; online patient portals; network-wide KPI dashboards enabling real-time performance monitoring.

D2 Processes	Quality management framework	ANMCS accreditation is mandatory but sets minimum compliance thresholds, not excellence. No public hospital holds Category I (highest) accreditation. Most achieve Category II ('accredited with recommendations') (ANMCS, 2024).	Certifications beyond ANMCS minimum: ISO 9001, ISO 15189. MedLife Maternitate: CONAS accreditation at highest confidence level; UNICEF 'Baby-Friendly Hospital' certification (MedLife, 2024).
	Lean, TQM, Six Sigma deployment	Largely absent. Quality committees documented as non-functional in governance case studies. Resistance to change and bureaucratic rigidity are systemic barriers. No evidence of systematic Lean or Six Sigma deployment in public hospitals (Duran et al., 2019).	Lean applied to supply chain and patient flow. Appointment scheduling optimised across network locations. Continuous improvement culture embedded in management contracts and performance reviews.
	Organisational improvement culture	Politicisation of management undermines continuity. Research confirms managerial decisions shaped by political and economic pressures rather than quality imperatives (Cumpăt et al., 2024). Voluntary rather than mandatory quality improvement mechanisms persist (Vlădescu et al., 2016).	Market competition drives continuous improvement. Patient satisfaction (NPS) measured systematically. Management tenure linked to performance rather than political cycle. Publicly reported KPIs create external accountability.
D3 Outcomes	Patient safety and clinical outcomes	Romania has the highest treatable mortality rate in the EU: 215 deaths per 100,000 population (2022), defined as deaths avoidable through timely healthcare (European Commission/OECD, 2025). Nosocomial infection reporting is acknowledged as underestimated.	Private networks report lower adverse event rates, linked to standardised clinical protocols and systematic infection control. Targeted specialties (oncology, maternity) show measurable outcome improvements.
	Patient satisfaction and access	Unmet medical care needs above EU average (Eurostat, 2024). No national NPS or satisfaction benchmarking. Waiting times unmonitored and unreported in standardised format.	Patient satisfaction systematically tracked via NPS. Online booking and reduced waiting times are competitive differentiators. Regina Maria and MedLife report satisfaction indicators in publicly available annual reports.
	Transparency and benchmarking	No national hospital benchmarking system. ANMCS publishes aggregated accreditation data, not comparative institutional performance indicators. Monthly public reporting became legally mandatory from October 2025, a first step toward transparency (FEMS/CFSMR, 2025).	Annual sustainability and performance reports published (MedLife, Regina Maria). Investor-grade operational KPIs publicly available. Network-level benchmarking enables internal comparison across facilities.

Source: Authors' own contribution, based on documentary analysis of sources cited in the table.

Note: Characterisations are qualitative and based on documentary analysis of the sources cited. They illustrate the direction and relative magnitude of the gap between sectors, not empirical measurement. Individual hospitals within each sector may deviate from the patterns described.

6.2 The structural gap as the primary constraint

The comparative analysis reveals a consistent pattern: the most pronounced asymmetry between the public and private sectors occurs at the structural level (D1). Romania's public health expenditure at 5.8% of GDP is the lowest in the European Union - less than half the EU average of 10.0% - translating into per capita spending of EUR 1,800 against an EU average of EUR 3,832 (European Commission/OECD, 2025). This chronic underinvestment is compounded by a physical infrastructure that has seen virtually no new construction: of 554 public hospitals operating in 2023, only four were built after 1989 (Statista, 2025). The structural deficit is thus not merely financial but material and technological.

Managerial autonomy - a structural precondition for any systematic quality improvement initiative - is severely constrained in the public sector. A governance assessment of Romanian public hospitals commissioned by the World Bank identified that 'incoherent policy design, outdated and often disjointed regulatory frameworks, and cumbersome administrative procedures limit managerial autonomy and obstruct efficiency gains' (Duran et al., 2019, p.199). The politicisation of management appointments has been a persistent feature of the system, documented across multiple reform cycles. By contrast, MedLife and Regina Maria operate with professional management structures accountable to performance indicators rather than political cycles.

6.3 The process gap: why tools alone cannot close it

At the process level (D2), the asymmetry is equally marked, but its causes are structurally determined. The ANMCS accreditation system - while mandatory for all hospitals - establishes minimum compliance thresholds rather than operational excellence. No Romanian public hospital has achieved Category I accreditation, the highest level in the national system (ANMCS, 2024). Governance studies document quality committees that were non-functional at the time of assessment and a systemic absence of the analytical capabilities required to drive continuous improvement.

The private sector, operating under competitive pressure and with professional management, has deployed Lean principles in supply chain and patient flow management, standardised clinical protocols across network locations, and implemented systematic patient satisfaction measurement. The qualitative difference is not primarily one of tool availability - TQM and Lean methodologies are accessible to public and private managers alike - but of the structural conditions that enable or preclude their effective deployment. This is the key analytical finding: the process gap is a consequence of the structural gap, not an independent failure.

6.4 The outcome gap and the invisible benchmark problem

The outcome dimension (D3) reveals a specific systemic failure: the absence of a national benchmarking infrastructure. Romania records the highest rate of treatable mortality in the EU - 215 deaths per 100,000 population in 2022, defined as deaths avoidable through timely healthcare intervention (European Commission/OECD, 2025). Yet these outcomes are not systematically linked, at institutional level, to the quality of hospital processes or structures. ANMCS publishes aggregated accreditation data but not comparative performance indicators by hospital.

This constitutes what this paper terms the invisible benchmark problem: in the absence of comparative outcome data at institutional level, the gap between structural and process maturity and patient outcomes remains analytically invisible to managers, policymakers, and patients alike. Without this visibility, there is no institutional pressure for structural reform - a negative feedback loop that perpetuates the status quo. The legislative requirement for monthly public reporting by hospital managers, introduced in October 2025 (FEMS/CFSMR, 2025), represents a necessary first step toward resolving this deficit, though not a sufficient one.

7. Theoretical propositions and discussion

The analysis in the preceding sections supports four theoretical propositions. These propositions derive their support from the documentary evidence reviewed and the logical structure of the proposed framework. They are not empirically tested here; they are offered as theoretically grounded claims intended to guide future empirical research.

Proposition 1 (P1). The Donabedian model can be reinterpreted as a hierarchical operational maturity framework, in which progress on higher-order dimensions is conditioned on sufficient maturity at lower-order dimensions. This proposition formalises the dependency relationship implicit in the Donabedian model. It aligns with operations management research showing that process improvement tools produce systematically weaker results in structurally deficient environments (Fottler, 1981; Arndt and Bigelow, 1995; Goldstein and Naor, 2005).

Proposition 2 (P2). In the Romanian healthcare context, the structural maturity gap between the public and private sectors constitutes the primary constraint on the transferability of operational excellence instruments to public hospitals. Romania provides an unusually clear setting for observing this constraint: the structural gap is extreme, well-documented, and cross-validated by multiple independent sources. P2 is an application of P1 to this specific national context and connects to the broader literature on contextual contingencies in management transferability (Allison, 1979; Bozeman, 1987).

Proposition 3 (P3). The deployment of process-level improvement tools in organisations with severe structural deficits will produce marginal or negligible results, regardless of the technical quality of the tools deployed. P3 provides a theoretical explanation for the recurrent empirical finding of high failure rates in TQM and Lean implementations in public-sector healthcare (Arndt and Bigelow, 1995; Swiss, 1992). Rather than attributing failure to implementation deficiencies, P3 locates it structurally - in the absence of preconditions that enable process tools to function effectively.

Proposition 4 (P4). The absence of a national hospital performance benchmarking system perpetuates the invisibility of the quality gap and reduces institutional pressure for structural reform - a negative feedback mechanism specific to publicly funded healthcare systems. P4 identifies a self-reinforcing systemic mechanism. Without comparative outcome data at institutional level, the consequences of structural and process deficits remain diffuse and politically manageable. Romania's highest-in-EU treatable mortality rate is a system-level indicator; without hospital-level benchmarking, it cannot be translated into managerial accountability. The 2025 legislative requirement for monthly public reporting represents a necessary, though not sufficient, step toward breaking this cycle.

7.1 Implications for management practice

For managers and policymakers, the framework proposed here offers a diagnostic sequence. Before committing resources to process-level interventions - quality certification programmes, Lean training, Six Sigma deployment - organisations should assess their structural maturity against the D1 indicators in Table 1. Where the structural deficit is severe, as in much of Romania's public hospital system, investment in process tools is likely to be wasteful unless accompanied by parallel structural reform.

The private sector's trajectory in Romania demonstrates that structural investment - in physical infrastructure, IT systems, and management autonomy - creates the enabling conditions for process excellence to take hold organically. This does not imply that the public sector should replicate the private model; the differences in mission, patient population, and financing are substantial. It does suggest that structural adequacy is a necessary precondition for quality improvement, regardless of sector. Policymakers focused on healthcare quality cannot achieve sustainable results by mandating quality standards on organisations that lack the structural foundations to meet them.

7.2 Limitations and directions for future research

This paper has several limitations that future research should address. First, the documentary analysis is selective: publicly available sources are more comprehensive for the private sector, which publishes voluntary annual reports, than for the public sector. A systematic documentary review using a broader source base - including hospital-level reporting data as they become available under the 2025 legislation - would strengthen the evidentiary foundation of the framework.

Second, the propositions advanced are theoretical and require empirical testing. A natural extension of this work would be a multi-case comparative study examining a matched sample of public and private hospitals against the D1-D2-D3 indicators in Table 1, using primary data collection through interviews, process audits, and outcome data.

Third, the framework is presented here in the Romanian context, but its logic is potentially generalisable to other healthcare systems characterised by a public-private asymmetry - particularly in Central and Eastern Europe, where similar structural patterns have been documented. Comparative applications across national contexts would test the generalisability of the propositions.

8. Conclusions

Operational excellence in healthcare organisations occurs when organisational efforts are aligned toward strategic goals, when culture is oriented toward continuous and deliberate performance improvement, and when these aims are pursued by design rather than coincidence. This paper has argued that achieving this state is not primarily a matter of selecting the right tools - TQM, Lean, Six Sigma, PDCA - but of ensuring that the structural preconditions for those tools to function are in place.

The paper's central focus is the reinterpretation of Donabedian's structures-processes-outcomes model as a hierarchical operational maturity framework. Structural maturity (D1) is a necessary precondition for process excellence (D2), which in turn enables reliable outcome improvement (D3). This hierarchical logic, applied to the Romanian healthcare system, reveals a structural maturity gap between the public and private sectors as the primary constraint on the transferability of operational excellence to Romanian public hospitals.

Four theoretical propositions follow from this analysis. They advance the argument that process tools deployed in structurally deficient organisations will produce marginal results (P1, P3); that Romania's extreme public-private structural asymmetry constitutes the operative constraint on quality improvement in the public sector (P2); and that the absence of a national benchmarking system creates a negative feedback loop that perpetuates structural under-investment by rendering its consequences invisible to managers, policymakers, and the public (P4).

As Donabedian himself observed, systems are merely mechanisms that allow quality to be achieved. The ethical and human dimensions of healthcare remain primary. But the structural and process conditions that enable those human dimensions to translate into measurable outcomes are the province of management science - and the subject of this paper.

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