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# SERVQUAL and New Public Service in Public Emergency Departments: A Systematic Review

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## Abstract

Emergency departments in public hospitals serve as the primary entry point for acute healthcare services. Empirical studies on service quality evaluation using SERVQUAL and public service perspectives remain dispersed across disciplines. This systematic literature review aimed to synthesize evidence on SERVQUAL dimensions and expectation–perception gaps, determinants of perceived service quality and satisfaction, and New Public Service (NPS) interpretations in public emergency departments. The review followed PRISMA 2020. Literature was searched in Scopus (2021–2026, Tier Q1 filter) and supplemented through snowballing, citation tracking, and hand searching. PICo-based eligibility criteria were applied. Sixty reports were included (22 from Scopus; 38 from other sources). Thematic synthesis was conducted because of heterogeneous study designs. Results indicated that the SERVQUAL five-dimensional model was the dominant assessment framework, with negative service quality gaps reported across dimensions, especially responsiveness and empathy in public emergency settings. The reported determinants included waiting time and patient flow (operational), health literacy, patient rights and equity (patient), and nurse autonomy, resilience, and facility readiness (organizational). Citizen participation, equitable access, and accountability, all NPS-related elements, were separately measured from the SERVQUAL measurement. No study identified in this review simultaneously applied SERVQUAL gap analysis, a public emergency department setting, and an explicit New Public Service framework. The review consolidates existing evidence and identifies an integrative research gap relevant to the evaluation of quality in regional public hospital emergency services.

***Keywords***: *emergency department, New Public Service, public hospital, SERVQUAL, systematic review*

## INTRODUCTION

The quality of emergency department services in public hospitals is a strategic issue that is receiving increasing attention in the international scientific literature, especially since the quality of emergency services can be assessed through the availability and readiness of facilities [1] and the demands of participation in the design of health services [2] Regional General Hospitals (RSUD) in Indonesia are public hospitals organized by local governments in the implementation of tiered health services and referral functions [3] while the emergency department (IGD) functions as the main gateway for the entry of patients who need intra-hospital emergency handling [4]. internationally, Demarquet et al. [5] affirmed that the emergency unit serves as the main entrance to the hospital, while Jimenez et al. [6] An analogue study in the Philippines reported that the emergency department became the patient's initial contact with acute services and faced high operational pressure. Samadbeik et al. [7] synthesizes that the root of the problem of patient flow in the emergency department includes overcrowding, limited human resources, and inadequate demand capacity.

Denberu et al. [8] reported that pediatric emergency departments were in a situation



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of limited resources and infrastructure, limited resources, and high patient volumes, while Damme et al. [9] In the Obstetric Emergency Service, General Hospitals identified limitations in human resources and infrastructure as the main barriers to quality. Kishimoto et al. [10] documenting that hospital restructuring in Japan affects the hospitalization patterns and access of the elderly in the community, so the impact of institutional reforms on the availability of services for the population needs to be evaluated holistically, these findings are in line with Rossi et al. [11] which identifies the tension between the logic of cost efficiency and the orientation of citizen services. Bukhari et al. [1] demonstrate that emergency service readiness can be measured through the WHO HHFA, with *Median Emergency Service Availability and Readiness Score* 76.47 in hospitals, although *Median Diagnostic Readiness* still relatively low (42.86). Damme et al. [9] revealed that the quality of obstetric emergency services is affected by training and supervision barriers, as well as facilitated by free services and the commitment of health workers. Jimenez et al. [6] reports that the operational governance of emergency departments, including the medical personnel assignment model, affects the efficiency, cost, and perception of service quality in non-urgent sections. Demarquet et al. [5] emphasized that emergency departments have diverse typologies based on territorial characteristics and patient profiles, so service quality improvement strategies cannot be generalized uniformly. In this context, evaluating the quality of emergency services in general hospitals requires a multidimensional approach that not only assesses clinical outcomes, but also structural dimensions and facility readiness [1], as well as the dimensions of the process and the perception of the user experience of the service [8], [9].

The literature shows that the SERVQUAL model is the most dominant instrument for measuring the quality of healthcare through the gap in expectations and perceptions on five dimensions: tangibles, reliability, responsiveness, assurance, and empathy, with the formula SQ = P-E [12], [13]. Fatima et al. [13] reports that Tangibility was the most dominant contributing factor in the 74 studies synthesized, followed by reliability, responsiveness, empathy, and assurance, as well as identifying contextual dimension adaptations such as Accessibility, Affordability, and Communication. Gilavand and Torabipour [14] found a systemic negative gap pattern in Iranian university hospitals, with Responsiveness and empathy repeatedly becomes a critical dimension. Empirical evidence in general general hospitals corroborates these findings, including Kalaja and Krasniqi [15], Al-Balas et al. [14] , Fan et al. [16], Gao et al. [17] [17], and Qiu et al. [18] [17] that report the dominant negative gap and improvement priorities in the responsiveness, empathy, and the service fee aspect. In the emergency department of a general hospital in particular, Hosseinzadeh et al. [19] applied five-dimensional SERVQUAL and found a negative gap in the Responsiveness and empathy, while Amarantou et al. [20] integrating the five dimensions of SERVQUAL into the technical-functional quality construct and confirming that waiting time is the most significant indicator of service quality in public emergency departments. Jonkisz et al.[12] adding that the classic SERVQUAL scale remains relevant as a tool for evaluating the quality of medical services, although it requires contextual adaptation given cultural differences in understanding patient expectations. The synthesis of these findings shows that the SERVQUAL framework has proven to be applicable to the evaluation of the quality of general hospital emergency services, but the pattern of gaps between dimensions is still



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heterogeneous and the measurement procedures are not yet completely uniform [19][20] [16].

The determinants of service quality perception in general hospital emergency departments include operational, patient, and organizational factors that can conceptually be mapped to the five dimensions of SERVQUAL. Amarantou et al. [16] reports that Waiting time has a significant negative effect on the perception of service quality and behavioral intentions, with different patterns between urban and provincial emergency units. Bhojak et al.[21] Find timeliness and access to care as the strongest predictor of patient satisfaction in the emergency department, while Samadbeik et al. [7] synthesizes that the root of the patient's flow problem includes Overcrowding, limited human resources, and incompatibility of demand capacity. On the patient side, Bartels et al. [22] report that members of the equity-deserving groups are more likely to feel judged and treated disrespectfully in emergency departments, Kaplan et al. [23] show attitudes of exercising patients' rights contribute significantly to satisfaction, and Akpınar Oruç and Sener [24] found a positive correlation between health literacy and emergency department patient satisfaction. On the health and organizational side, Abere et al. [25] reported that the autonomy of nurses is related to the quality of services in public hospitals, Vaisi Raygani et al. [26] found a positive association between nurse resilience and quality of care in emergency departments, as well as Yayehrad et al. [27] Identifying a culture of patient safety as an important factor in regional public hospitals. These findings confirm that the evaluation of the quality of emergency services cannot be separated from the operational context, equity of access, and capacity of public service institutions [22], [25], [20].

In line with these empirical findings, the perspective of New Public Service (NPS) offers an interpretive lens that emphasizes citizen orientation, participation, Co-production, equity of access, and public accountability in health services. Lloyd et al. [2] report that public participation in healthcare design is in line with the principles of Co-production, although formal evaluation of outcomes is still limited. Rossi et al. [11] Identify conflicts between the logic of cost efficiency and the logic of citizen service orientation in health public service innovation, which is relevant for regional hospitals facing Trade-offs Limited budget versus service quality demands. Janati et al. [28] emphasizing that public accountability through evidence-based decision-making requires the translation of quality evaluation findings into auditable managerial policies, with stakeholders values and expectations as a source of evidence of the decision. Yusefi et al. [28] empirically connecting frameworks Responsiveness WHO with SERVQUAL service quality ($r = 0.585$), which provides a theoretical basis for linking citizen orientation to the five dimensions of SERVQUAL. Nonetheless, explicit integration between the SERVQUAL gap analysis and the NPS perspective in public hospital emergency departments has not been identified in the existing corpus of literature: SERVQUAL studies in emergency departments [29], [20] has not been interpreted through public service theory, while the study of citizen participation and equity [22], [2] does not map the findings to a five-dimensional SERVQUAL framework. This gap indicates fragmentation between the SERVQUAL-based service quality measurement path and the citizen-oriented public service interpretation path [13], [11].

The importance of closing these gaps is even more urgent considering that public health service reform requires an evaluation that not only measures patient satisfaction,



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but also answers the principles of dignified, responsive, fair, and accountable service [28], [2]. Kishimoto et al. [10] and Rossi et al. [11] Collectively, it emphasizes that public hospital policies must balance institutional efficiency with access and needs of citizens. Bukhari et al. [1] and Denberu et al. [8] reported that the quality of emergency services is influenced by structural readiness and service processes that are not always reflected in clinical indicators alone. Demarquet et al. [5] adding that the heterogeneity of emergency unit typologies demands a synthesis of evidence that takes into account variations in the context of facilities. In such a situation, Systematic Literature Review be the right approach to synthesize dispersed and heterogeneous empirical evidence in a transparent, replicable, and auditable manner [30], [31]

Munn et al. [31] affirms that systematic review designed to identify and critically assess all empirical evidence to answer specific research questions, as opposed to Scoping Review which is more conceptual mapping-oriented. Snyder [30] added that the transparency of inclusion and exclusion criteria determines the validity of the conclusions of the literature review as an independent research method. Therefore, this research was carried out as a Systematic Literature Review guided by PRISMA 2020 [1] with thematic synthesis for heterogeneous studies [32], in order to evaluate the quality of emergency department services of public hospitals through the SERVQUAL framework interpreted through the NPS perspective. The novelty of the research lies in the first integration between the measurements Service Quality Gap SERVQUAL-based and modern public service paradigm in the context of emergency units as public health services, which places patients as citizens within a framework of dignified, responsive, and accountable evaluation [29], [28], [11].

Based on this description, this study aims to synthesize empirical evidence regarding the evaluation of the quality of emergency department services in public hospitals through the SERVQUAL framework and the NPS perspective. The objective is directed to answer three research questions formulated with the PICo framework (Population, Interest, Context). The first question maps the dimensions of service quality and the gap patterns of expectations and perceptions based on SERVQUAL, including instrument adaptation and gap/IPA analysis [33], [34], [17]. The second research question identified the patient, healthcare worker, and organizational factors that influence perceptions of quality, satisfaction, and behavioral intent [35], [25], [20]. The third question analyzes the interpretation of literature through the perspective of citizen orientation, access justice, Co-production, and public accountability and its integration with SERVQUAL [2], [11], [28],

The relationship of this research with the existing literature lies in its position as a synthesis that bridges the dominance of the SERVQUAL method [12],[13],[14], with a citizen-oriented public service agenda [2] in the emergency unit setting which has been studied separately [19], [20],[22]. Theoretical contributions are in the form of integration of service quality measurement and public service paradigms, methodological contributions in the form of gap analysis synthesis and improvement priorities [17], [18] and practical contribution to the policy of improving emergency services of the hospital [10], [36] The novelty of the research lies in the patient's position as a citizen within the framework of a dignified, responsive, and accountable evaluation [37],[11]. Thus, the formulation of this research problem is: (1) How are the dimensions of service quality and the pattern of perception expectation gap reported in the evaluation study of public



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hospital emergency units based on SERVQUAL? (2) What factors are reported to affect the perception of service quality, satisfaction, and behavioral intent in the emergency department of public hospitals? (3) To what extent does the empirical literature interpret the quality of emergency department services of public hospitals through the perspective of NPS and how does it integrate with SERVQUAL-based evaluation?

**METHOD**

This research uses a design Systematic Literature Review (SLR) to synthesize empirical evidence of evaluation of the quality of services in public hospital emergency departments based on the SERVQUAL framework and perspectives New Public Service (NPS). This approach was chosen because it is able to identify and critically assess all empirical evidence to answer specific research questions, different from Scoping Review which is more concept mapping oriented [31]. The implementation of the review follows the guidelines Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 [34], with transparency in literature search reporting as recommended by the PRISMA-S extension [38]. The research questions are formulated based on the PICo framework (Population, Interest, Context) [32]: the population of the emergency department of public hospitals and users of their services; Interest measurement of SERVQUAL service quality, determinants of satisfaction perception, and interpretation of public services; the context of emergency services as public health services. The PICo framework was chosen because the main focus of this study is to explore the phenomenon of service quality and fulfillment of public values (Interest) in patients and emergency institutions (Population) in a regional general hospital environment (Context). Although this review includes quantitative and mixed methods studies, the use of PICo allows for a broad conceptual synthesis of the dynamics of governance and service perceptions without limiting the methodological design to a specific medical intervention.

Inclusion criteria require journal publication Peer-reviewed that discuss the quality of services in the emergency room of public/regional hospitals, using or discussing SERVQUAL and/or the value of public services (accountability, fairness, patient rights), with relevant empirical or conceptual designs; on the Scopus pathway, publications are limited to the range of 2021–2026 and journal quartiles Tier Q1. The Scopus search was limited to 2021–2026 to capture emergency department research produced after the acute phase of COVID-19, when crowding, waiting time, and the organization of public hospital services were widely reconsidered. The year distribution of the retrieved records, which increased after 2019 and peaked in 2024, supported this window. The limit applied only to the Scopus search. Citation tracking and snowballing were not restricted by year, so earlier foundational studies could still be included.

Exclusion criteria include non-emergency room/hospital population, Outcome purely clinical without a quality of service dimension, editorial or commentary without empirical data, and full text is not available after the effort retrieval standard. The search was conducted on the Scopus database on June 28, 2026 with four keyword blocks (hospital Emergency Care Quality; evaluation services quality in hospital with SERVQUAL; Public service quality in hospital; Regional Public Hospital); Full search strings, database filters, and access dates are reported as per PRISMA-S [38] The distribution chart of the year of the search results shows an increase in publications since 2019 with a peak of 40 records in 2024, so the limitation of the publication period on the Scopus line is justified. The distribution graph of publications as shown in Figure 1 is as follows:



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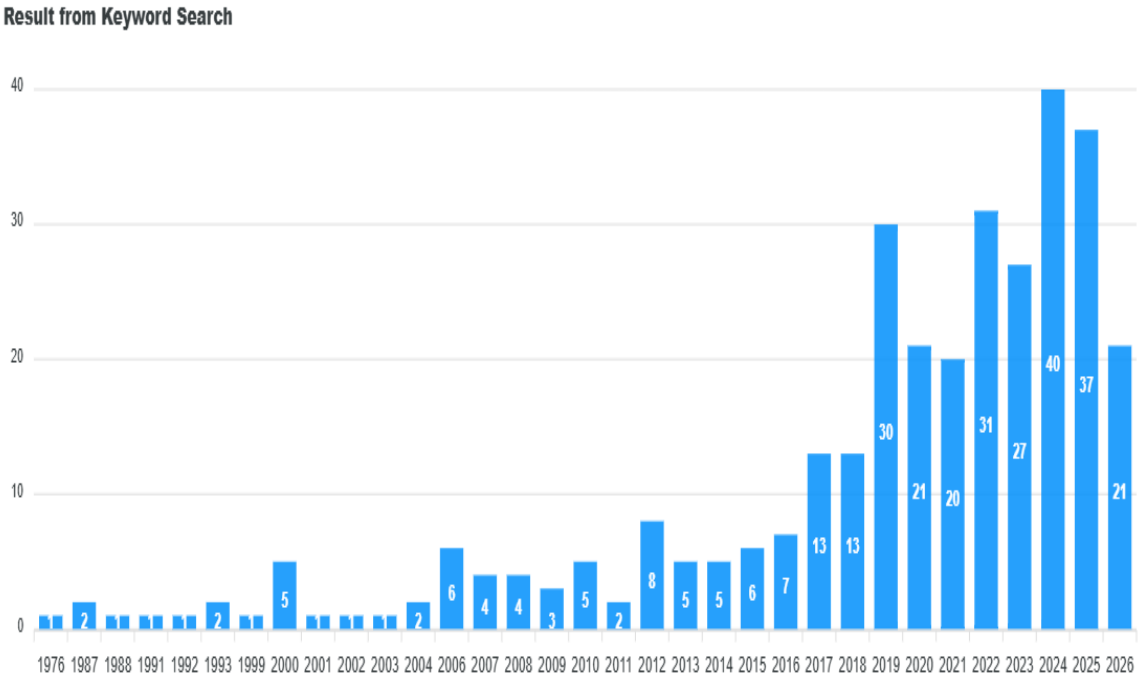



**Figure 1. Research Publication Distribution Graph**
(Source: ……)

Before Screening title and abstract, the Scopus record is deduplicated (n = 4), filtered outside the range 2021–2026 (n = 151), and filtered quartile Tier Q1 (n = 104), leaving 68 records to filter. Complementary search via Snowballing bibliography, Citation Tracking, Hand searching, and Google Scholar identified 38 additional reports that were evaluated with the same exclusion inclusion criteria. The source of each report's identification is documented on the extraction form. The principle of transparency, inclusion and exclusion criteria is the basis for the validity of the review process as an independent research method [39]

The research subjects were not individuals, but the unit of analysis was in the form of 60 study reports that met the inclusion criteria, consisting of 22 studies from Scopus and 38 studies from other sources. The selection flow is reported in the PRISMA 2020 diagram. of the 327 Scopus recordings, 68 recordings were filtered by title and abstract, 39 were excluded, 29 full texts were searched, 6 were not obtained, 23 were assessed eligibility, 1 was excluded at the full-text stage, so that 22 studies were included; plus 38 studies from other sources, with a total of n = 60. The PRISMA 2020 diagram is shown in the following Figure 2:



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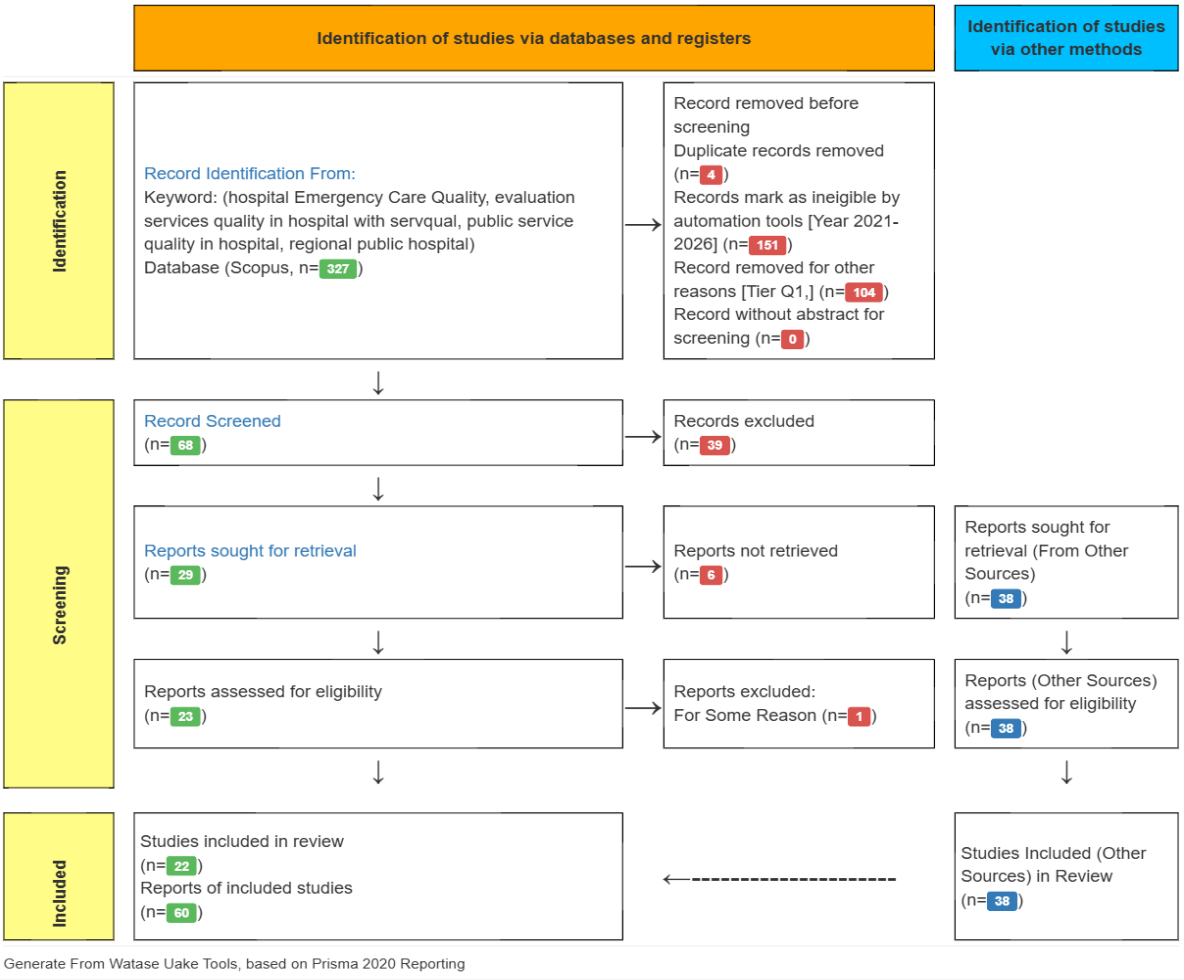



**Figure 2. Research PRISM Diagram**
(Source : …….)

The research instruments include standardized data extraction forms and Checklist PRISMA 2020 [34]. Methodological quality assessment is carried out differentially, primary studies are assessed by Checklist Critical Appraisal Joanna Briggs Institute (JBI) according to their respective designs [14], while a systematic review in the corpus is assessed with AMSTAR 2 [40]. Extraction variables include study identity (author, year, country), study design, population, SERVQUAL instrument (five dimensions, procedures Gap/IPA), determinants of quality and satisfaction perception, as well as elements of public service interpretation (citizen orientation, equity of access, Co-production, accountability). The data collection procedure is carried out through systematic extraction from the full text of each study that passes the selection, with documentation of the reasons for exclusion at each stage so that the process can be audited and replicated [39]. Given the heterogeneity of study design, measurement instruments, and Outcome between publications, quantitative meta-analyses were not performed and synthesis was presented narratively according to Cochrane guidelines [13]. Data analysis using



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thematic synthesis for qualitative findings [32] and narrative synthesis for quantitative studies and systematic review [12], [13]. The findings are coded, grouped into descriptive and analytical themes, then arranged according to three problem formulations, namely (1) dimensions and patterns Service Quality Gap SERVQUAL, (2) determinants of patient, health workers, and organizational aspects, and (3) integration of NPS perspectives with SERVQUAL evaluations. The thematic synthesis of this study employed a hybrid approach combining inductive and deductive coding. Initially, line-by-line coding was conducted inductively to extract all empirical findings from the qualitative, quantitative, and mixed methods studies without preconceived categories. Descriptive themes were then developed by analyzing these codes within a matrix of SERVQUAL dimensions (tangible evidence, delivery, responsiveness, assurance, and empathy) and factors influencing customer satisfaction. In the final stage, analytical themes were constructed using the lens of New Public Service (NPS) theory. The use of NPS principles—such as serving citizens, prioritizing the public interest, and upholding accountability—allowed the synthesis to encompass not only the technical-operational quality of emergency services but also broader governance dimensions related to providing public value, equitable access, and protecting patient rights in regional public hospitals.

Contradictions between studies were reported explicitly. Studies only utilize secondary data from publicly available scientific publications, so the approval of the research ethics committee is not required according to the principles of literature-based secondary research [12].

## RESULTS AND DISCUSSION

### Result:

Of the 60 study reports included, thematic synthesis was grouped according to three research questions (RQs).

### RQ1: SERVQUAL Dimension and *Service Quality Gap*.

Five-dimensional SERVQUAL framework (tangible, reliability, responsiveness, assurance, empathy) reported as the dominant instrument in the evaluation of health service quality [29], [13], with variations in contextual dimension adaptations such as Economy [16] and Access and Affordability [8]. In public hospitals Smart Healthcare, Qiu et al. [18] using four dimensions of adaptation (ability, application, platform, effectiveness), not the classic five dimensions. Fatima et al. [13] report Tangibility as the most dominant dimension (72.9% of 74 studies), followed by Reliability and Responsiveness (59.5% each). Pattern Service Quality Gap negative (SQ = P-E) was reported in a variety of public hospital settings, with the order of the gap varying between studies: Responsiveness (mean gap of 1.04 in the meta-analysis of Iranian university hospitals; expectations > perceptions) [14], Economy > Responsiveness > Empathy [16], as well as a mean gap of 0.58 on 24 items [18]. Kalaja and Krasniqi [15] reported that only 38% of respondents were very satisfied (n = 800) in Albanian general hospitals, with Reliability as the highest gap predictor ($\beta = 0.578$). In the emergency department of a general hospital in particular, Hosseinzadeh et al. [19] reporting a negative gap on Responsiveness (-0.99) and Empathy (-1.22) with n = 200 emergency room patients, while Amarantou et al. [20] evaluating two Greek public emergency rooms (n = 169) and report Waiting time negative effect on quality perception ($\beta = -0.59$; $p < 0.05$). Al-Balas



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et al. [41] reported systematic gaps between MOH (2.76) and private (3.36) hospitals in Jordan's health services (n = 908), which is relevant to the issue of equity in public services even though it is not an emergency room setting. Complementary procedures Importance Performance Analysis (IPA) is reported as a method of prioritizing item improvements, among others in Gao et al. [17] and Qiu et al. [18], although both studies were not located in the emergency room.

**RQ2: Determinants of Quality Perception, Satisfaction, and Behavioral Intent.**

The operational determinants in the emergency room are conceptually mapped to the dimensions Responsiveness and Reliability: Bhojak et al. [21] report timeliness and access to care based on PSQ-18 (not a SERVQUAL instrument) as the strongest predictor of emergency room patient satisfaction ($\gamma = 0.88$; $p < 0.01$). Park et al. [42] Documenting at a private tertiary hospital Single-center in South Korea the median increase length of stay Emergency room from 3.9 to 4.5 hours post-policy target time, and Samadbeik et al. [7] synthesizes that the root of the problem of the flow of the emergency room includes Overcrowding, limited human resources, and incompatibility of demand capacity. On the patient side in the emergency room, Akpınar Oruç and Sener [24] found a positive correlation of total health literacy with satisfaction ($R = 0.227–0.324$), Kaplan et al. [43] reported that attitudes of using patients' rights contributed significantly to satisfaction ($\beta = 0.261$), and Bartels et al. [22] Identify disrespectful experiences in members equity-deserving groups. Denberu et al. [22] reported a negative correlation between the satisfaction of a pediatric emergency unit patient with a rural domicile (Kendall's tau-b = -0.120; $p < 0.05$). On the organizational side, Vaisi-Raygani et al. [26] found a positive relationship between nurse resilience and the quality of emergency room care ($r = 0.275$), Bukhari et al. [26] Reporting Median Emergency service availability and readiness 76.47 (public and private hospitals) with Diagnostic readiness Public Hospital 42.86 in Pakistan, Abere et al. [25] reported 53.5% of nurses had working autonomy both in Ethiopian public hospitals, and Yayehrad et al. [27] reported a good patient safety culture of only 48.8% in regional public hospitals, both of which were contextually relevant although not specific to the emergency room

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**RQ3: New *Public Service* (NPS) Perspective and SERVQUAL Integration.**

Lloyd et al. [27] reports that public participation in healthcare design in high-income countries results in diverse Outcome, but formal evaluation Outcome only reported in 43.3% of studies and has not been supported by adequate cost-benefit analysis. Janati et al. [44] found a positive attitude of the hospital manager towards Evidence-based management (91%), despite the comprehension systematic review is still limited (26.67%). Yusefi et al.[2] connecting the framework Responsiveness WHO with SERVQUAL service quality ($r = 0.585$; $p < 0.001$) in hospitalized elderly people. Rossi et al. identified the tension between the logic of cost efficiency and citizen service orientation in public health service innovation in Finland. The author's analytical interpretation is the dimension Responsiveness, Insurance, and Empathy SERVQUAL can be read as a responsive public service indicator [28], while the tension of the efficiency of the orientation of the citizens [11] can be used as a conceptual analogy for RSUD instead of direct empirical findings in the emergency room. There have been no studies in the corpus that simultaneously integrate the analysis Gap SERVQUAL, public



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hospital emergency room settings, and NPS framework explicitly [29], [20], [22], [2].

## DISCUSSION

### Discussion of RQ1: SERVQUAL Dimension and Service Quality Gap

RQ1 asked about the pattern of SERVQUAL dimensions and gaps in the evaluation of public hospital emergency rooms. Findings confirm state of the art [29],[13]: Five-dimensional SERVQUAL remains dominant, with contextual adaptation Economy [45] and Access/Affordability [13]; Qiu et al. [18] Wearing four dimensions Smart Healthcare which differs from the classic model. The negative gap pattern is consistent with the meta-analysis of Gilavand and Torabipour [14] in the Iranian university hospital and the study of the public hospital Fan et al. [16], Kalaja and Krasniqi [15], Qiu et al. [18] Heterogeneity of gap sequences Responsiveness highest on meta-analysis [14], Economy highest [16], Reliability Gap Predictor [15] emphasizing that improvement priorities must be contextual, in line with heterogeneous emergency room typologies [5] At the public emergency room, Hosseinzadeh et al. [29] applying the classical gap E-P, complementing Amarantou et al. [20] that uses derivative constructs without explicit gaps. Both emphasized Responsiveness in line with the IPA procedure in the study of the relevant public hospital [17], [46]. This procedural gap between E-P and SEM/derivative constructs explains the need for standardization of gap measurement in public hospital emergency rooms. The largest negative gaps in public emergency departments fall on responsiveness and empathy because both are produced in the encounter itself [19], [20]. Responsiveness fails when waiting time, overcrowding, limited staffing, and uneven patient flow delay help [20],[7]. Empathy fails in that same setting because workload leaves little room for individual attention, which is consistent with the larger empathy gap than responsiveness gap reported among emergency patients [19].

Significance of RQ1: Citizens' expectations systematically exceed perceptions [14], [19], [41]. Differences between private MOHs and public hospital services [41] and rural disparities in satisfaction of pediatric emergency departments [39] strengthen the argument for evaluation of emergency departments as a matter of equity in public services, not just clinical outcomes. AlOmari [33] and Sharifi et al. [47] report gap per item (Listening skills, Empathy) that are not always reflected in dimensional aggregate scores, so this review emphasizes the importance of gap analysis per item and IPA [17], [46] as a complement to the dimension score in planning the repair of the emergency room of the hospital.

### Discussion of RQ2: Determinants of Quality and Satisfaction Perception

RQ2 identifies the factors of patients, health workers, and organizations that affect the perception of emergency room quality. Operational determinants are conceptually mapped to Responsiveness/Reliability: Lead time and access of the dominant predictor [20], [21] including the findings of Bhojak et al. [21] based on PSQ-18, not SERVQUAL supported by national indicators [48] and synthesis Patient Flow [7]. Park et al. [42] in private tertiary hospitals Single-center and Al-Mashat et al. [49] Adding a policy dimension: Measurable time targets don't always improve the perceived quality of citizens. Patient determinants expand Insurance/Empathy: Patients' rights [43], health literacy [24], equitas [22], as well as rural disparities in pediatric emergency departments [8] emphasized that the satisfaction of the emergency room is determined by the dignity



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of the treatment, not the speed alone. Zehra et al. [50] and Woo and Choi [51] complement with Patient Experience and intent to revisit as an outcome of behavioral intentions. Determine Organizational Ecology/Resilience nurse [25], safety culture [27], facility readiness [1] linking institutional capacity to the SERVQUAL dimension, although some of the evidence comes from general public hospitals, not specific emergency rooms. Bukhari et al. [1] reported a median readiness of 76.47 (and private) with Diagnostic readiness RS 42.86. Damme et al. [9] and Jimenez et al. [6] emphasized that human resources and governance barriers affect the quality of emergency rooms holistically. The synthesis of RQ2 shows that the evaluation of the quality of the hospital emergency room requires a multilevel approach that is aligned with the Donabedian framework of structure-process-outcome [1], [8]. Utino et al. [52] reported waiting time of <1 hour ($\beta = 0.729$) and privacy ($\beta = 0.529$) as predictors of perception quality in Ethiopian hospitals, indicating that similar determinants can be transferred to the context of the hospital emergency room even though the settings are different. Kishimoto et al. [10] added that hospital reform must be judged from citizen access, not just institutional efficiency.

**RQ3 Discussion: NPS Perspectives and SERVQUAL Integration**

RQ3 assesses the interpretation of the quality of the emergency room through the perspective of service. Lloyd et al. [2] Reporting Participation in Line Co-production, but formal evaluation Outcome only reported in 43.3% of studies. Rossi et al. [11] identifies the strain of cost efficiency versus citizen orientation in Finnish healthcare as a conceptual analogy, rather than direct empirical evidence in the hospital emergency room. Janati et al. [37] affirm Stakeholder values as a source of proof of decisions, even though literacy systematic review low (26.67%). Yusefi et al. [28] Providing an empirical bridge Responsiveness WHO SERVQUAL ($r = 0.585$) in hospitalized elderly people. Author's analytical interpretation: Responsiveness, Insurance, and Empathy SERVQUAL can be read as an indicator of responsive and dignified service [28], while the tension of the efficiency of the orientation of the citizens [11] relevant as a policy lens of the hospital. However, Bartels et al. [22] than Kaplan et al. [23] reported the equity/rights of patients in the emergency room without SERVQUAL, while Hosseinzadeh et al. [19] and Amarantou et al. [20] implement SERVQUAL without an explicit NPS lens. This fragmentation confirms Research gap SERVQUAL-NPS integration [2], [11], [44]. Du et al. [53] and Damme et al. [9] report respect, privacy, and the voice of patients/health workers as crucial attributes that are in line with the principles of citizen orientation and Co-production, but has not been mapped to the five dimensions of SERVQUAL. Kunz et al. [54] and Al-Balas et al. [41] affirming the systematic disparity in the quality of the private sector as an issue of persistent access equity in health services.

## CONCLUSION

This systematic literature review synthesizes 60 evaluation reports on the quality of emergency room services in public hospitals based on SERVQUAL and perspectives New Public Service (NPS) according to PRISMA 2020 [34]. The findings confirm the dominance of five-dimensional SERVQUAL with Service Quality Gap systemic negativity in public hospitals [13], [14], in particular Responsiveness and Empathy in public emergency rooms [19], [20]. Perceived determinants include wait time and patient flow [38], [21], [7], health literacy, patient rights, and equity [22], as well as nurse



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autonomy [25], nurse resilience [26], and emergency facility readiness [1]. The literature has not integrated analysis General Gap SERVQUAL with the NPS framework explicitly in the emergency room of a public hospital [2], [11], [58]. The contribution of this review is to public administration. Emergency department services in public hospitals are a matter of public service governance as well as of clinical service quality. Equity, accountability, citizens' rights, responsiveness, and the public interest are obligations that the institution owes to citizens. SERVQUAL records how those citizens experience the service. Read through the New Public Service, the same evidence asks whether the institution has met those obligations. No study identified in this review measured the obligations together with a SERVQUAL gap analysis in a public hospital emergency department.

The implications of the findings emphasized that the evaluation of the emergency room of the hospital requires a SERVQUAL-based citizen perception instrument that is interpreted through public service orientation and evidence-based policies [19], [28], [28]. For practitioners and regional policymakers, improvement priorities are focused on Responsiveness (waiting time) [28], [20], [21] and Empathy/Insurance (Patient Rights, Equity) [43], [22]. Limited review on Scopus 2021–2026, filters Tier Q1, proportions Snowballing high, and design heterogeneity that limits meta-analysis [34], [31], [39]. Generalization to Indonesian hospitals requires caution because the majority of the evidence is from LMIC and settings outside Indonesia [19], [1], [54]. Future research is suggested integrating five-dimensional SERVQUAL with analysis Gap, science, and explicit NPS lens in the emergency room of the Indonesian Hospital [56], [2], The follow-up agenda needs to examine the three-level determinants of citizens' perception of quality through longitudinal design and public participation in the evaluation Outcome auditable [2]

## DECLARATION OF GENERATIVE AI

"In the preparation of this document, the author has utilized Cursor Ai to compile the structure of the framework and writing ideas and then reviewed, edited, and modified the resulting text. The author also uses Watase UAKE Ai in the preparation of SLR. The author is solely responsible for the entire content."

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