

Chapter 5

Managing Customer Relationship Quality in Hospitals

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LEARNING OBJECTIVES

Upon completing this chapter, you should be able to do the following:

1. To highlight the importance of customer orientation in hospital management.
2. To establish a hospital management model based on customer orientation.
3. To understand the concept of customer relationship quality and its components.
4. To identify the tools hospital managers have available for managing customer relationship quality.

KEYWORDS

customer orientation, relationship quality, satisfaction, trust, loyalty, perceived value, facilities, professionalism, service quality, price, non-monetary costs, emotional value, social value.

INTRODUCTION

The health system is one of the sectors with the greatest impact on developed societies. Its importance lies not only in the overwhelming social significance involved in managing such a critical service for human life but also the financial resources it manages and the number of employees it employs. For example, the World Health Organization (WHO) calculates that world health expenditure in 2005 was \$4.4 trillion. This huge quantity of resources is managed by diverse organizations whose mission is taking care of health. The national health systems are organized differently, but at global level, it can be said that the health service is a public one. According to the WHO, the resources

devoted to general government and social insurance account for 59 percent of total world spending, compared to 37 percent on private insurance and out-of-pocket expenses.

In practically all countries, public systems coexist with private systems, although there are considerable differences between nations. In Brazil, Egypt, India, Mexico, South Africa and USA, the private system accounts for more than 50 percent of total spending, while in France, Great Britain, Japan and Germany the private system accounts for less than 25 percent of the total in 2009 (Table 5.1).

Table 5.1 Private Expenditure on Health as % of Total Expenditure on Health (2009)

Albania	58.8%	Cuba	7.3%	Kenya	56.7%	Saudi Arabia	37.6%
Argentina	37.6%	Democratic Republic Congo	55.3%	Luxembourg	16.0%	South Africa	56.2%
Australia	32.0%	Egypt	60.5%	Malaysia	44.3%	Spain	26.4%
Bangladesh	67.0%	France	22.1%	Mexico	51.6%	Sudan	72.5%
Bolivia	35.4%	Germany	23.1%	Namibia	45.0%	Sweden	18.5%
Brazil	56.4%	Guinea	91.8%	Nicaragua	45.2%	Turkey	24.9%
Burkina Faso	50.3%	Haiti	78.2%	Pakistan	65.2%	Ukraine	45.0%
Canada	29.4%	Honduras	33.7%	Paraguay	61.0%	United Kingdom	15.9%
Central African Republic	65.8%	India	69.7%	Poland	27.7%	USA	52.3%
China	47.5%	Italy	22.1%	Republic of Korea	41.8%	Zambia	41.4%
Colombia	28.9%	Japan	17.7%	Russian Federation	36.6%		

Source: Author's Presentation from WHO (2012)

Other data show the differences between countries: spending per capita on health services in the developed countries is more than \$1,000, with per capita figures above \$5,000 in the United States and Norway and less than \$200 in China and most African countries (Table 5.2).

A significant characteristic of the health services sector is its importance at a macro-economic level. The management of these resources is an important aspect that affects

not only the basic good that is people's lives but also the management efficiency of a large quantity of economic and human resources.

Table 5.2 Total Health Expenditure per Capita 2009 (US\$)

Equatorial Guinea	804	USA	7960	Luxembourg	8262	Australia	3945
Botswana	581	Canada	4519	Norway	7533	Japan	3754
South Africa	521	Bahamas	1714	Switzerland	7185	New Zealand	2702
Namibia	297	Chile	802	France	4840	Republic of Korea	1184
Algeria	181	Argentina	734	Germany	4723	China	191
Congo	67	Brazil	734	United Kingdom	3440	India	44
Nigeria	67	Cuba	672	Italy	3323		
Central African Republic	18	Paraguay	147	Spain	3032		
Madagascar	18	Honduras	134	Turkey	575		
Democratic Republic Congo	17	Nicaragua	104	Russian Federation	476		
Ethiopia	16	Bolivia	90	Ukraine	200		
Eritrea	11	Haiti	40	Armenia	129		

Source: Author's Presentation from WHO (2012)

From a microeconomic point of view, concerning the management of an organization that runs health services, the first issue to bear in mind is the coexistence of public services with private services and the management implications of this. The main difference between public and private services lies in the fact that, while the former does not seek to make financial profits, the latter must be accountable to shareholders who demand a return on their investments. However, the most widespread trend at the moment considers that this different nature does not justify different management.

A second aspect to bear in mind is that the health service network usually has two levels of care. First there is a primary care service, which is more generalist, dealing with the

most common diseases and making a preliminary diagnosis of more complex diseases. Second there is a specialized care service that can be offered by an independent network of health professionals who are specialists in a particular branch of health or that can be grouped in complex organizations offering an integrated specialized service. These multiservice organizations are hospitals. In the case of public hospitals, user satisfaction is part of the organizational mission, and in the case of private health services, income and profits are important but they, too, require a satisfactory customer relationship.

In this chapter we focus on hospitals. Complex hospitals are a key element in national health systems. The main objective of this chapter is to show how important it is for hospitals to maintain quality relationships with their clients and to identify the available tools for hospital managers to deliver value and improve customer relationship quality.

This chapter highlights the importance of hospitals' customer orientation. It highlights the importance of managing the quality of relationships as a condition of customer-oriented strategy, defining the three key elements to be monitored on a balanced scoreboard: commitment, trust, and satisfaction. It also describes the tools the hospital manager must employ to provide appropriate value to the patient that has a positive impact on relationship quality. In this sense, hospital managers should establish specific programs and actions related to facilities, professionalism of health personnel, perceived quality, monetary cost and nonmonetary costs, and emotional and social values.

THE IMPORTANCE OF HOSPITALS' CUSTOMER ORIENTATION

The importance of patient relationship quality in hospital management lies in the fact that it forms part of the essence of any health organization's mission, and also in the influence customer management exerts over outcomes. To achieve the objectives of any organization, it is necessary to care for customers and maintain customer orientation. Bigné, Moliner, and Sánchez (2005) demonstrated the existence of a causal relationship between market orientation and business results measured through profitability, sales growth, and marketing effectiveness. In the case of a hospital, this customer orientation has more important implications than it does for any other type of organization, as the customer's health has an incalculable value. It is impossible to imagine a hospital without users, or one that patients could not go to. Because of all this and regardless of their public or private nature, hospitals must put the user first in their priorities.

To help in understanding the relationship between customer management and financial

results, Kaplan and Norton (2009) provided a good operational diagram when they established their balanced scoreboard proposal. This model identifies four groups of indicators any organization should establish to control the implementation of its strategy: financial, customer, internal business, and learning and growth. If a hospital invests in developing people and learning, its staff will be better able to carry out its internal processes, allowing it to achieve loyal and satisfied customers, leading to good financial outcomes. This sequence is clear for the case of a private hospital, where the financial results take the form of a growth in income or in profits. In the case of a public hospital, the financial results do not take the form of profit figures, but rather the achievement of financial sufficiency. None of this affects a hospital as it fulfils its mission to achieve loyal and satisfied customers.

Hospital customer orientation is therefore profitable. For hospitals, the concept of customer must be defined more precisely than for other multiservice organizations. Patients undoubtedly make up the principal public for a hospital, as they directly receive the diagnosis and treatment. But as the customers evaluate the services offered by a hospital, the people who accompany the customer exert a direct influence on the customer/patient. Those companions, either entirely or partially, have the same experience as the patient, and they also assess the service provision. The level of involvement of both stakeholders is high, and their perceptions feed off each other's evaluations. To appreciate the importance of the patient's companion, we can use two extreme examples. The first example is the case of a child, whose experience of hospital services is low, and the parent accompanying the child takes the initiative in the service. In another example, a patient with a serious illness cannot get out of bed. In this case, their companion assesses the services existing beyond the four walls of the room. This broad concept of a hospital customer is important when it comes to identifying the stakeholders, strategy, and specific action programs.

After making the broad definition of a hospital customer, we take a look at how to manage relationships between a hospital and its users. Figure 5.1 illustrates the causal relationship guiding the management logic of these relationships. Following Kaplan and Norton (2009), it is clear there is a direct relationship among customer management, financial results, and the hospital's mission. This chapter suggests that, to achieve the hospital's mission and financial outcomes, the hospital must achieve a high-quality relationship with its customers. Hospital relationship quality is measured through three variables: customer loyalty, customer trust, and customer satisfaction. These three variables should be incorporated into the hospitals' Balanced Scoreboards.

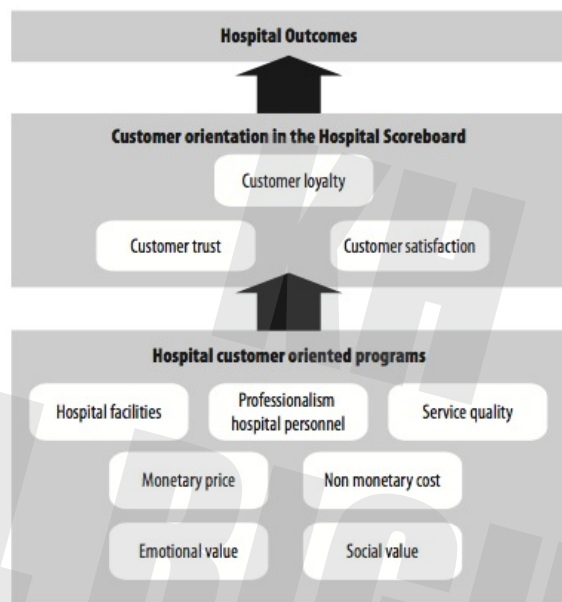


Figure 5.1 HOSPITAL CUSTOMER RELATIONSHIP QUALITY AND ITS ANTECEDENTS.

But, at a second level, it is necessary to establish programmes making it possible to affect these three indicators. The literature on perceived value makes an important contribution in this respect. Moliner (2009) compares the existence of causal relationships between the value perceived by a hospital customer and relationship quality. This means that, from a customer point of view, a hospital should be oriented towards setting up programmes that provide value for its customers. More specifically it is suggested that it should establish programmes taking seven aspects into account: hospital facilities, personnel professionalism, service quality, monetary cost, non-monetary costs, emotional value and social value. In the following pages, we will describe the details of this customer management model.

CUSTOMER RELATIONSHIP QUALITY IN THE HOSPITAL SCOREBOARD: OLD WORDS, NEW PARADIGM

The relationship established between two parties may take different forms, for example, a contract. This formula is widespread at the level of relationships in the hospital context where public and private insurance is taken out. Independent of the formal aspects that regulate a relationship, each participant in the exchange evaluates it him- or herself.

This evaluation is decisive for the continuity of the relationship; hospitals must be familiar with the key mechanisms that guide customer behavior. The concept of customer relationship quality is a reflection of customer's evaluation of the hospital's actions.

Relationship quality can be seen as a construct of other key components that reflect the nature of a relationship between hospitals and customers (Hennig-Thurau, Gwinner & Gremler, 2002). Gummesson (1987) considers *relationship quality* to be the quality of the interaction between a customer and a hospital, and it can be interpreted in terms of accumulated value.

The most recent literature agrees in identifying the components of relationship quality. For the case of a hospital, Moliner (2009) talks about customer satisfaction with the hospital, customer trust in the hospital, and customer loyalty to the hospital.

CUSTOMER SATISFACTION WITH THE HOSPITAL

According to the disconfirmation paradigm, *satisfaction* is a comparison of performance to expectations (Oliver, 1981). But, according to Oliver (1999), this is a definition based on what the customer does, and not on the psychological meaning of satisfaction. He therefore proposes that "satisfaction is defined as pleasurable fulfilment" (Oliver, 1999). That is, the customer senses that consumption fulfils some need, desire, or goal, and that this fulfilment is pleasurable. Thus, satisfaction is the patient's sense that hospital service provides outcomes against a standard of pleasure versus displeasure. This view of satisfaction reflects, on the one hand, its cognitive nature (comparing expectations against performance) and, on the other, its affective nature (associated feeling of pleasure). The level of satisfaction achieved by the customer is therefore a signal of the relationship's health (relationship quality).

Satisfaction's impact on hospital choice is particularly important (Kessler & Mylod, 2011). Hospitals with higher patient satisfaction scores have lower mortality rates and better process measures (Edlund, Young, Kung, Sherbourne, & Wells, 2003; Gesell, Clark, Mylod, Wolosin, & Drain, 2005; Jaipaul & Rosenthal, 2003). Satisfied patients are more likely to adhere to recommended treatment (Finkelstein, Harper, & Rosenthal, 1999) and less likely to sue for malpractice (Stelfox, Gandhi, Orav, & Gustafson, 2005). With respect to loyalty, patients say they would consider changing hospitals in response to satisfaction information (Boshoff & Gray, 2004; Sofaer, Crofton, Goldstein, Hoy, & Crabb, 2005), and probably would return to the hospital for treatment if they were satisfied (Garman, Garcia, & Hargreaves, 2004). Kessler and Mylod (2011) found a statistically significant link between patient satisfaction with the hospital and patient loyalty to the hospital.

Patient satisfaction is generated by their own experience with the hospital's service, but it is also influenced by their companion's satisfaction. While patients received a medical service that was important to them, their companions based their evaluations on

more peripheral, but no less relevant, aspects. It is clear that the main reason for patient satisfaction is that their expectations of a cure for their disease have been fulfilled. In addition, an important emotional component depends not only on the patient's feelings but also on the feelings and evaluations of their companion. Companions often perceive details that patients do not consciously observe due to their concern for the technical aspects of the medical service.

In this sense, hospital managers must remember how important it is to measure the level of patient and companion satisfaction and to study their expectations. Mittal and Baldasare (1996) found that private hospitals that fail to meet patient expectations lose market share. These analyses undoubtedly enable hospitals to better adapt their services to customers' requirements. A final element that the hospital manager should bear in mind is the level of service at his or her hospital compared to other hospitals. The customer makes an evaluation based on comparisons with the similar experiences of others. The patient may make that comparison based on their own or a companion's personal experience or a third party may have told the patient of their experiences with another hospital. In this sense, it seems appropriate to compare the service level of one hospital against other, similar hospitals.

PATIENT'S LOYALTY TO THE HOSPITAL

Customer loyalty is one of the elements most studied by organizations. Normally in consumer markets, customer loyalty is understood as repeat purchase behavior. Translating this concept to the hospital sphere is inappropriate, as customers do not go to a hospital of their own free will, but rather, because a need for medical service arises. We consider that, in this context, loyalty means the patient has a more or less favorable predisposition toward the hospital. This predisposition can take the form of choice of hospital at the time when the illness arises, positive comments that patients and companions share with third parties, and complaint behaviour and a willingness to forgive mistakes.

In the case of a private hospital, where there is freedom of choice and a direct payment is made for each visit, the hospital manager has a clear interest in developing loyal patients who choose the hospital when they need it, disseminate positive messages about it, and show understanding about mistakes (Anbori, Ghandi, Yadav, Daher, & Su, 2010). In the case of a public hospital, where the patient does not have freedom of choice and where hospital incomes derives from taxes, loyalty takes the form of positive messages and understanding when there are mistakes.

Ultimately, the hospital manager must understand customer loyalty as the patient or companion's level of commitment to the hospital. Morgan and Hunt (1994) consider that the commitment-trust pairing is the indivisible axis that leads to the efficiency, productivity, and effectiveness of relationships. The basis for maintaining relationships is the keeping of promises, such that if a promise is unfulfilled, the patient will not

return to the hospital and the patient-hospital relationship will end (Moliner & Calarisa, 1997).

Some authors consider commitment to be the highest level of relational bond (Dwyer, Schür, & Oh, 1987). The literature has established two dimensions of commitment: affective commitment and calculated or cognitive commitment (Geyskens, Steenkamp, Scheer, & Kumar, 1996; Wetzels, de Ruyter, & Van Birgelen, 1998). The former captures the emotional elements of commitment; the latter refers to a more rational analysis.

A patient's (and companion's) affective commitment is based on emotions, such as the feeling of belonging and respect for the hospital (Geyskens & Steenkamp, 1995). Numerous studies have shown that individuals remain in a relationship because positive feelings emerge that associate feelings of belonging with a high degree of respect for the other party (Geyskens & Steenkamp, 1995; Geyskens et al., 1996; Morgan & Hunt, 1994).

Patient's (and companion's) cognitive commitment is an exercise of economic calculation, and two types can be distinguished: negative and positive. A patient's cognitive commitment is negative when the relationship is maintained due to the costs and penalties associated with abandoning it (Young & Denize, 1997). As soon as alternatives appear, relationships based on negative commitment dissolve (Rusbult, 1980, 1983). A patient's commitment is positive if the motive for remaining in the relationship is the possibility of obtaining benefits. This commitment is said to be based on cognitive value (Rusbult, 1980).

PATIENT'S TRUST IN THE HOSPITAL

In addition to commitment, trust is the other key element the hospital must establish to maintain a long-term relationship (Morgan & Hunt, 1994). The patient must feel trust in the hospital, according to Morgan and Hunt (1994), as this is the basic element that permits the promises and relationships to be established and maintained. The patient's (and companion's) trust implies that the customer does not question the hospital and personnel's good intentions, that the promises made do not generate uncertainties in the patient, and that the communication between the parties is honest, open, and frequent (Czepiel, 1990).

At a general level, the patient's trust comprises two major dimensions: honesty (belief that the hospital will keep its word and has the capacity to do so, the staff are trustworthy and honest, and they have integrity and a good reputation) and benevolence (belief that the hospital and its personnel are interested in the patient's well-being) (Garbarino and Johnson, 1999; Morgan & Hunt, 1994). In this sense, patient trust is an affective construct because it is based on two dimensions with a strong emotional component.

MANAGING CUSTOMER RELATIONSHIP QUALITY THROUGH CUSTOMER VALUE PROGRAMS

Customer satisfaction, customer loyalty, and customer trust are three indicators the hospital manager must monitor, as a negative change in any of them could have a direct impact on the organization's results. In the case of a private hospital, financial outcomes can suffer immediately, because there are few costs associated with change. In the case of a public hospital, a negative change in an indicator can lead to a reduction in the hospital's subsidy in the medium and the long term. Neither of the two organizations would be aligned with the health organization's mission.

The question is: What tools does the hospital manager have to manage customer relationship quality? The literature establishes the necessity of managing the organization's value chain and, more specifically, establishing programs that provide value to patients and their companions.

Perceived value is the essential result of marketing activities and is a first-order element in relationship marketing (Oh, 2003; Ravald & Grönroos, 1996). Perceived value is understood as a construct configured by two parts, one of benefits received by the patient (economic, physical, social, and relationship) and another of sacrifices made (price, time, effort, risk, and convenience) (Bigné, Moliner and Callarisa, 2000; Cronin, Brady, Brand, Hightower, & Shemwell, 1997; Cronin, Brady, & Hult, 2000; Oh, 2003).

Regarding the elements that must be considered in perceived value management, by general consensus the functional factors include quality and price; the affective factors include feelings and social impact (Sánchez, Callarisa, Rodríguez, & Moliner, 2006; Sheth, Newman, & Gross, 1991a, 1991b). Starting from there, important efforts to test this theoretical proposal were made by Sweeney and Soutar (2001), who designed a measurement of perceived value (PERVAL).

On the basis of Sheth et al. (1991a, 1991b) and the PERVAL scale by Sweeney and Soutar (2001), Sánchez et al. (2006) developed the GLOVAL model, which identifies the perceived value elements. Based on this proposal, Moliner (2006, 2009) established the dimensions for hospital perceived value: hospital facilities, hospital personnel professionalism, service quality, monetary cost, non monetary costs, emotional value, and social value. Moliner (2009) found that the establishment of programmes to improve these dimensions has a direct impact on customer satisfaction, customer loyalty, customer trust, and therefore, on outcomes.

HOSPITAL FACILITIES

Facilities are an important element at several levels. On one hand, possessing technological medical equipment determines the possibilities of treating some diseases. Although most patients and their companions are incapable of assessing the technical

value of the medical equipment, this does not prevent them making a subjective evaluation of it, either directly or indirectly, influenced by third parties. On the other hand, the facilities and the comfort they provide are another aspect assessed by both the patient and the companion. In this sense, it is appropriate to take care over elements related to hospital accommodation services, including everything from the cleanliness and comfort of the rooms to the catering service. Moliner (2009) points out the special care needed so that the facilities promote the consultation privacy; that are well organized and tidy; that are spacious, modern, and clean; and that are easy to find and to access with good transport links.

In Moliner's (2009) study, focused on Spanish hospitals, facilities were found to significantly influence customer relationship quality. In Spain, a large public hospital system coexists with a small private network of hospitals. In the case of public hospitals, Moliner (2009) noted that facilities significantly influenced patient satisfaction. In the case of private hospitals, the facilities not only influenced patient satisfaction, they also affected trust in the hospital. This suggests that well-maintained facilities makes a positive impression on the customer, which translates into greater trust, apart from the fact that the level of comfort generates satisfaction in the patient.

These findings indicate that designing modern and comfortable facilities and establishing internal processes that enables staff to keep them clean and well organized are important. Given the importance of clean facilities, the hospital is well advised to institute communication programs that allow the best use of hospital facilities, as they generate trust in potential patients and their companions.

PROFESSIONALISM OF HOSPITAL PERSONNEL

The doctor-patient relationship is technically known as an *agency relationship*; that is, there is asymmetry of information, as the doctor has some specialized knowledge that neither patients nor their companions have, so the latter are incapable of technically assessing the service received. The diagnosis and treatment of a disease are beyond the reach of the patient or companion, and they must trust in the doctor's competence and await the result of the treatment delivered.

Patients and their companions assess whether the medical staff and their assistants know their job well, are up-to-date in their knowledge, whether the advice provided by the staff has been very valuable, and whether the staff know about all the services offered by the hospital. This means the patients and companions indirectly assess the technical capability of the health staff and whether the diagnosis and treatment are appropriate.

In Moliner's (2009) study, the health staff's professionalism has a considerable effect on patient satisfaction regardless of the public or private nature of the hospital. The essence of the health service is understandably at the center of customer's evaluations. In the case of a private hospital, the health staff's professionalism directly influences patient trust. As with facilities, patients and their companions need indications that the

hospital deserves their trust and that they have made the correct choice. Because of this, the hospital needs to carry out external communications with patients and their companions affecting the technical training of health staff.

Tortosa, Moliner, and Sánchez (2009) show that the employment satisfaction of health staff has a positive influence on the quality of the result (an appropriate diagnosis and treatment), which is the main indicator of patient satisfaction. The aim of this study was to analyze the importance of a hospital's internal market orientation, understood as internal communication management. The most important recommendation for hospital managers lies in the necessity to establish internal communication programs aimed at health staff, because communicating the organization's objectives and strategies generates job satisfaction.

SERVICE QUALITY

The content of the health service is associated with the technical aspect and the diagnosis and treatment of the disease. Another aspect is how the service is offered, which is associated with empathy (the way the patient is treated), the hospital organization's capacity to respond, and the patient care processes and protocols. A hospital must identify the different moments of truth—the moments when a patient comes into contact with the organization by email or telephone or through personal attention. Diagnoses and treatments require patients to consult various specialized hospital services. The synchronization between patients and hospital becomes a key aspect for customer perceived quality. Thus, hospital management needs to study whether the services are well organized, whether quality is maintained throughout customer and companion relationships, whether the level of quality is acceptable compared to other hospitals, whether the staff are always kind and friendly, and whether the medical team provides an accurate diagnosis and treatment.

Moliner's (2009) study determined that, although service quality affects patient satisfaction, it fundamentally affects user trust. In light of this, hospital managers should set up programs to foster empathy for patients and deal with them in a friendly way. Managers should also design a process map that allows a continuous coordination among the specialized services. These actions are necessary because the health staff are the main agents in service quality management. Along these lines, Tortosa, Moliner, and Sánchez (2009) highlighted the fact that, when internal communication programs are established, they generate greater job satisfaction among hospital (not only health) staff, which results in a higher quality of patient/companion interaction. The importance of the interpersonal component of private hospital service quality was confirmed in other studies (Anbori et al., 2010).

MONETARY COST

Monetary cost is one aspect that affects patient's evaluation of a service. Obviously, price has an economic component, involving the money payment the patient must make for the health service received. In the case of a public hospital, payment is made indirectly through taxes or with public insurance. In the case of a private hospital, payment is made via private insurance or directly to the hospital. But cost also has a psychological component. In the case of a complex product or service that is difficult for the customer to value, the monetary cost becomes an indicator of service quality: the customer usually associates a high price with high quality. The price issue is not exclusively the issue of the hospital as, to make a more accurate analysis, private or public insurance should be considered.

Patients and their companions also assess such aspects as whether the money spent is fully justified, whether the service is worth the cost, and whether the financial cost is high or not.

Moliner (2009) found that, for private hospitals, monetary cost is a particularly important evaluation criterion in patient satisfaction. In the case of public hospitals financed through taxation or public insurance systems, the user's perception of the monetary cost is that it is a free service. Because of this, private (and private insurance) hospitals could establish loyalty programs with discounts for patients who repeatedly choose the hospital when they need a health service. In the case of a public hospital financed through taxation or public insurance, discount programs make no sense.

NONMONETARY COSTS

The literature on services has identified a series of nonmonetary costs that affect service evaluation and that, in the case of hospitals, appear frequently. These nonmonetary costs involve expenditures of time and effort as well as psychological costs. Most nonmonetary costs are associated with waiting lists to access a medical professional. Not only is there a time cost, a psychological state of anxiety is generated in patients and their companions when the wait is considered too long (Liu et al., 2010).

It is not easy to manage waiting patients because it is almost impossible to forecast demand. A hospital can move from a quiet state to overcrowded in a few minutes, and these crises are difficult to manage without requiring less urgent cases to wait. The only solution is to have an excessively large staff available to deal with any eventuality, but this is not a viable solution. The hospital manager must design adaptable and flexible processes while studying the points in time when demand historically rises or falls. This does not guarantee a reduction in waiting lists, but it can mitigate them to some degree.

The literature on queue (waiting list) management stresses the importance of offering patients and their companions information to reduce their anxiety and the negative feelings generated by uncertainty (Liu et al., 2010).

EMOTIONAL VALUE

The feelings of patients and their companions are present in any evaluation of the hospital and the services received. Emotional involvement is high because what is at stake is so important. This high level of emotional involvement leads to the emergence of positive and negative feelings that greatly affect the perception of the value and quality of the relationship. The generation of positive feelings by hospital staff (relaxation, understanding) or negative feelings (hassle, dislike, powerlessness) has a great deal to do with the staff's verbal and nonverbal communication, as well as the details of the different moments of truth (encounters between patients and staff) (ibid., 2010). This can be summed up in one question: did the patient and the companion like the hospital experience?

Emotional value entirely affects relationship quality, as it leads to satisfaction, trust and commitment from patients and their companions. The positive or negative feelings generated during the hospital service experience have a high level of influence on patient loyalty. Even, the effect of satisfaction with hospitalization experience to patient's loyalty would be larger than overall satisfaction's effect (Kessler & Mylod, 2011).

There are no programs for managing emotional value beyond staff incentive systems and training programs, as patient and companion feelings are the result of all the hospital programs. This does not mean that hospital managers must not take user's emotions into account. It is essential that the generation of user's emotional value is present in all hospital programmes, particularly those aimed at managing moments of truth.

SOCIAL VALUE

Fishbein and Ajzen (1975) consider that people's behavior is determined by two fundamental factors: a personal or attitude factor and a social or normative factor. The *social factor*, which we call social value, refers to the influence of the social environment on behavior. Social value is the perception of what the companion and other people important to the patient think about what the patient should or should not do with respect to the hospital service (Dick & Basu, 1994). When a person feels unwell for a while, family members or friends often pressure that person to visit a specialist or a hospital. Some people consult acquaintances about an ailment they have shared. In these conversations, comments and suggestions are made about the best specialist or best hospital for treating the disease. Human beings are social and much of their behavior is guided by the family and friends environment.

The choice of a hospital and the evaluation of the service received are usually mentioned by people close to the patient, who make positive or negative evaluations of the

health experience. Individuals or reference groups important to the patient may like or dislike some aspects of the hospital service, which can lead to psychological rewards or penalties for family and friends. The patient's personality moderates the importance of the social factor and reference groups, as some people are more sensitive to others' comments and evaluations and other people are immune to others' opinions.

Hospital managers can try to influence the social environment, for example, through a marketing plan that views community and former patients as among the hospital's important stakeholders. Just as important is establishing a specific policy concerning companions, with a strategy especially designed for them while they are at the hospital, and carrying out post-service follow-up with companions. Finally, in relation to the impact on community, branding helps to generate reputable brands that usually achieve a good social evaluation and, therefore, a positive image and social opinion.

CONCLUSIONS

Throughout this chapter we have tried to demonstrate the need for hospital managers to incorporate customer relationship quality indicators into the hospital Balanced Scoreboard. High levels of satisfaction, trust, and loyalty from patients and their companions are translated into good financial outcomes. That means a hospital must adopt a customer orientation, analyzing the expectations and perceptions of patients and their companions and making decisions based on this information. High levels of satisfaction means that patients, with all their emotional and social needs, must become the focus of hospital strategy, regardless of whether the hospital is public or private.

For the customer relationship management model presented, it is proposed that management undertake specific programs to provide patients and their companions with value. Several specific programs have been proposed that should form part of an integrated strategy.

One program should be based on the constant care and maintenance of facilities, which not only influence customer satisfaction but also generate trust.

A second program should be to design internal processes that enabling management to coordinate the hospital's services and specialties so that all moments of truth (contact between customer and staff) are satisfactory and require minimum costs in terms of the patient's time.

A third program should focus on staff, promoting continuous professional training and individual customer orientation (empathy, likeability). Along these lines, health staff selection should focus on professional training as well as on emotional intelligence and customer orientation.

A fourth program should focus on marketing, integrating an internal communication plan and an external communication plan. The former should translate the hospital's objectives and strategies to all staff, to align them with institutional objectives and promote greater job satisfaction. With the latter (external) communication, the idea should be to generate a positive social image of the hospital. This should be integrated into a branding strategy based on the most important attributes of the hospital, which will generate social reputation.

Programs should not focus exclusively on functional elements, but should also pay special attention to affective factors. The feelings generated in the patient during the service experience are caused fundamentally by relationships with the hospital and the contact personnel. It is therefore necessary, not only to care for the intangible aspects of the hospital services, but also to ensure that contact personnel show empathy.

REVIEW QUESTIONS

1. Insurance organizations are the third pillar of the health system. They control the care team and collect insurance premiums from users. How do the insurance companies affect the quality/price relationship perceived by patients?
2. A hospital's hiring practices vary among countries. In some cases, the staff are public employees and in others they are hired based on goals. How do you think this labour contract affects the health staff in terms of their professionalism and the quality of service they offer users?
3. Quality measurement and perceived value are essential to properly managing the relationship quality. In the case of a hospital, with multiple services, how do you think customer relationship quality could be measured? What about customer perceived value?
4. Patients' companions play an important role in evaluating the hospital experience. However, their expectations are not normally studied. Suggest a methodology for studying companions' expectations.

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