CHAPTER II

LITERATURE REVIEW

This chapter consisted of three main parts. First part included service loyalty concept. Second part was related to factors influencing service loyalty which were composed of 4 topics: perceived service quality, satisfaction emotions, accessibility factors, and socio-demographic factors. Third part concerned primary care units.

I. Service Loyalty Concept

There is consensus among researchers that loyalty is a complex construct. Customer loyalty has been measured as either repurchase behavior or repurchase behavior combined with an attitudinal and cognitive component. Early conceptualizations of customer loyalty focused on behavioral outcome measured as repeat purchasing intensions or the purchasing sequence behavior of consumer. Jacoby and Chestnut (7) concluded from their analysis that repetitive purchase solely might not underline the reasons for brand loyalty. The further analysis needed to detect true brand loyalty required an assessment of consumer beliefs, affect and intention within the traditional consumer attitude structure. A conceptualization of loyalty provided incorporated both a behavioral and attitudinal component which reflect in the brand loyalty offered as

> Brand loyalty is 1) the biased (i.e. nonrandom), 2) behavioral response (i.e. purchase) 3) expressed over time, 4) by some decision-making unit, 5) with respect to one or more alternative brands out of a set of such brands, and 6) is a function of psychological (decision-making, evaluative) processes. (8)

Dick and Basu (9) emerged a customer loyalty framework that combined both behavioral and attitudinal measures. Loyalty was determined by a combination of repeat purchase levels and relative attitude measured by attitudinal strength and attitudinal differentiation. Relative attitude with repeat patronage leaded to the four specific conditions related to loyalty as shown in figure 1.

Relative Attitude	Repeat patronage: High	Repeat patronage: Low
High	Loyalty	Latent Loyalty
Low	Spurious Loyalty	No Loyalty

Figure 1 Service loyalty classification scheme
Source: Dick and Basu, 1994

The person classified as loyalty is the most preferred of the four conditions, occurred when a consumer had high repeat patronage and high relative attitude. On the contrary, the person has no loyalty when she or he had a low relative attitude combined with low repeat patronage. Latent loyalty existed when a consumer had a high relative attitude but did not exhibit high repeat patronage due to some situational or environmental variable. While spurious loyalty occurred when a consumer had a low relative attitude accompanied by high repeat patronage. This could occur if there were no alternatives in a category or if choice is made strictly on past experiences and habits.

According to attitude structure, Oliver (10) pointed that consumers could become loyalty at each attitudinal phase relating to different elements of the attitude development structure. Consumers are theorized to become loyalty in a cognitive sense first, then later in an affective sense, still later in a conative manner, and finally in a behavioral manner called "action inertia". Each phases of loyalty were described as

Cognitive loyalty: In the first phase, the brand attributes information available to the customer indicated that one brand was preferable to its alternatives. This stage, loyalty based on brand belief only and could be based on prior knowledge or on recent experience-based information.

Affective loyalty: At the second phase, a linking or attitude toward the brand had developed on the basis of cumulatively satisfying usage occasions.

Conative loyalty: The third phase of loyalty development was conative or behavioral intentions stage, as influenced by repeated episodes of positive affect toward brand. Conation implied a brand-specific commitment to repurchase.

Action loyalty: In this stage, the motivated intention in the previous loyalty state was transformed into readiness to act and coupled with the overcoming of obstacles.

Therefore, psychological strategies were suggested to achieve ultimate loyalty.

Some researchers distinguish loyalty as a psychological outcome and repurchase intentions as a behavioral outcome. Blodgett et al. (11) measured complaint behavior as a psychological outcome of loyalty. Butcher et al. (12) defined loyalty excluding repeat purchase as the enduring psychological attachment of a customer to a particular service provider. Attachment was reflected through advocacy of the service to others, tendency to resist switching to alternate service providers, identification with the service provider and having a relative preference for the service ahead of other competitors.

A further aspect of loyalty identified by other researchers was cognitive element which was incorporated with other two aspects of loyalty including behavioral and attitudinal loyalty. It was suggested that two-dimensional model of service loyalty, consisting of behavioral service loyalty and a combination of attitudinal and cognitive loyalty, provided a better representation than the three dimensions of behavioral loyalty, attitudinal loyalty, and cognitive loyalty.(13) Cognitive loyalty was based on customers' conscious decision-making process in the evaluation of alternative brands before purchasing. In other words, consumers would make an explicit comparison between what they give and get. The operationalization of the cognitive element of service loyalty included what first comes to mind when making a purchase decision (14), price tolerance (15), considering only one service provider when needing this type of service (16).

Service loyalty regarded interpersonal relationships developing between service providers and service consumers. (17-18) Therefore, relational variables and

relationships quality were linked to a service loyalty related outcome as a multi-dimensional service loyalty.

Zeithaml et al. (19) proposed multi-dimensional framework of customer behavioral intension in services, comprised of four main dimensions, purchase intentions as behavioral outcome, word-of-mouth communication and price sensitivity as attitudinal and cognitive loyalty, and complaining behavior as interpersonal relationships.

Table 1 Service loyalty dimensions

Word-of-mouth communications
1. Say positive things about XYZ to other people
2. Recommend XYZ to someone who seeks your advice
3. Encourage friends and relatives to do business with XYZ
Purchase intentions
4. Consider XYZ your first choice to buy . . . services
5. Do more business with XYZ in the next few years
6. Do less business with XYZ in the next few years
Price sensitivity
7. Take some of your business to a competitor that offers more attractive prices
8. Continue to do business to a competitor that offers more attractive prices
9. Pay a higher price than competitors charge for the benefits you currently receive from XYZ
Complaining behaviour
10. Switch to a competitor if you experience a problem with XYZ's service
11. Complain to other consumers if you experience a problem with XYZ's service
12. Complain to external agencies, such as the Better Business Bureau, if you experience a problem with XYZ's service
13. Complain to XYZ's employees if you experience a problem with XYZ's service

Source: Zeithaml et al., 1996

The empirical study of Bloemer et al. (20) indicated that four dimensions of service loyalty, consisting of purchase intentions, word-of-mouth communication, complaining behavior and price sensitivity, could be applied in four different service industries including entertainment, fast food, supermarkets and health care.

In conclusion, loyalty employed in this study was a multi-dimension framework of four dimensions. Even though primary care services are available as free services because of the universal health coverage scheme, but price sensitivity

could be measured as willingness of clients to pay for current service. Therefore, loyalty was measured as utilization intention, positive word-of-mouth, price sensitivity and complaining behavior of primary care unit clients.

II. Factors Influencing Service Loyalty

1. Perceived Service Quality

The relationships between service quality and service loyalty was explored from previous studies in many dimensions. Boulding et al. (21) found positive relationships between service qualities and repurchase intentions and willingness to recommend. Four dimensions of service loyalty, word-of-mouth, purchase intention, price sensitivity and complaining behavior, were studied in tangible and intangible services including fast food restaurant, shopping mall, movies theater and bank in Thailand. The study indicated that perceived service quality and service loyalty were significantly and positively correlated in all four studied service categories. (22)

de Ruyter et al. (23) determined three dimensions of loyalty including preference, price indifference and dissatisfaction respond. There were significant positive relations between perceived service quality and preference loyalty and price indifference loyalty but no significant relationship between perceived service quality and dissatisfaction response was found in health services. Bloemer at al. (20) further analyzed a pattern of service loyalty relationships at the individual dimensions across four differences industries and indicated that for the health care services, empathy was an important determinant of both purchase intentions and word-of-mouth. In addition, it was found that assurance exhibited a positive in price sensitivity and empathy played a major role in determining service loyalty in term of recommendation and purchase intentions.

Linking between service quality and service loyalty was also found in health care context by other researchers. Alden et al. (24) measured client loyalty to reproductive health care clinics in the Philippines and Thailand as likelihood to engage in positive word-of-mouth and return to the clinic in the future. It was found

that perceived service quality significantly related to loyalty in both Thailand and the Philippines. The study in Taiwan indicated that technical service quality and functional service quality were also positively related to patient loyalty. (25)

Early conceptualizations of service quality were based on the disconfirmation paradigm employed in physical products. Gronroos (26) indicated that good perceived quality would be obtained when the experienced quality met the customer's expectations as shown in Figure 2.

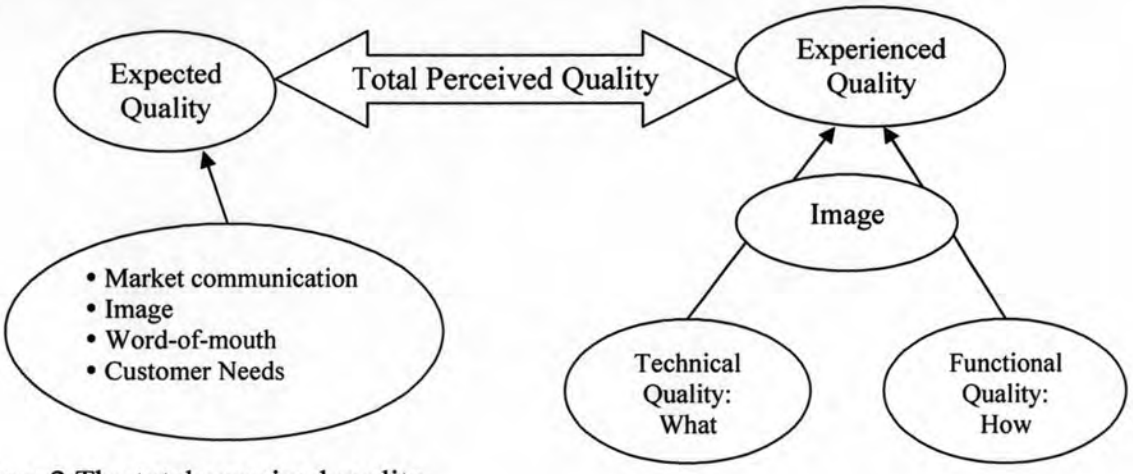

Figure 2 The total perceived quality
Source: Gronroos, 1990

Like Gronroos, Parasuraman, et al. proposed a gap model of service quality based on a disconfirmation paradigm. The service quality was concerned as the gap between customers' expectations and perceptions. Figure 3 showed that service quality evaluation is a function of the expectations consumers bring to the service situation and the process and output quality they perceived. (27-28)

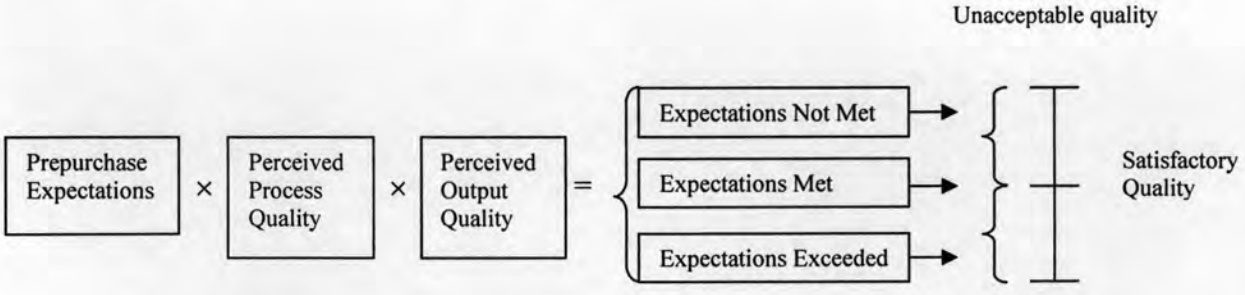

Figure 3 Continuum of perceived service quality
Source: Parasuraman et al., 1985

A disconfirmation paradigm resulted in SERVQUAL, a widely used instrument for measuring customer expectation and perceptions performance of service quality developed by Parasuraman et al. (29) SERVQUAL consisted of 22 items and five dimensions of service quality dimensions including tangibility such as the physical facilities, equipment, appearance of personnel; reliability; responsiveness; assurance which comes from employees' knowledge, courtesy and ability to convey trust and confidence; and empathy.

However, SERVQUAL had been subjected to a number of theoretical and operational criticisms. Cronin and Taylor (30-31) suggested that the performance-minus-expectation was an inappropriate basis for use in the measurement of service quality. They investigated that SERVPERF, performance-based measures, provided a more construct-valid explication of service quality. This finding was consistent with the findings of other researchers such as Brown et al., Buttle, and van Dyke et al. who indicated that the use of difference scores in calculating SERVQUAL contributes to problems with reliability, discriminant validity, convergent validity, and predictive validity of the measure. (32-34) In addition, SERVQUAL had been criticized for focusing on the process of service delivery rather than outcomes of the service encounter.

A model employed to measure perceived service quality in this study was performance-based. Service quality was measured not only the process of service delivery but also the structure and outcome of service. This model was based on Donabedian (35) theory which suggested that there are three approaches to assessing the quality of care including structure, process and outcome. This theory was supported by Gronroos (26) who indicated that the quality of service as it perceived by customers has two dimensions which were a technical or outcome dimension and a functional or process-related dimension as showed in figure 2. Technical quality was what customers received in their interaction with service provider where as functional quality was how the service was performed.

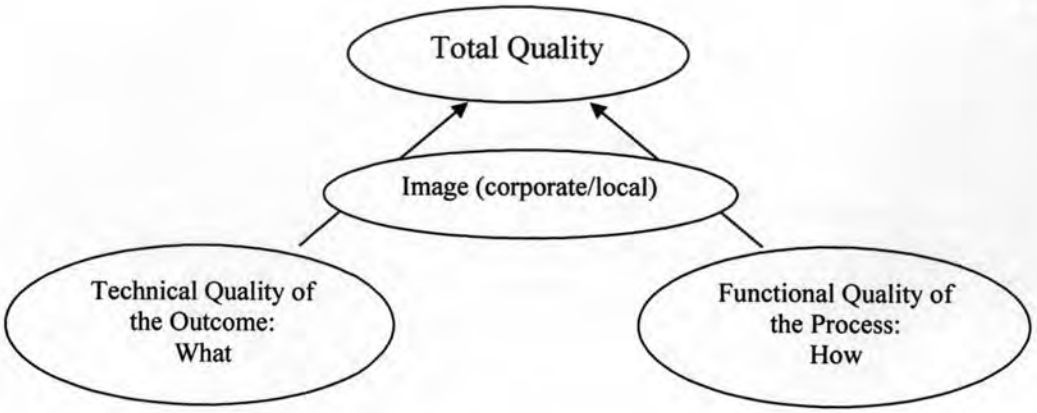

Figure 4 Two service quality dimensions
Source: Gronroos, 1990

Rust and Oliver (36) developed another conceptual model to measure service quality consisting of three dimensions, which are named as service product, service delivery and service environment. Service product refers to the technical quality of the service. Service delivery refers to the functional quality of the service. Finally, the service environment includes the internal and external environment. The empirical study of Brady and Cronin (37) indicated that customers formed service quality perceptions on the basis of their evaluations of three primary dimensions: outcome, interaction and environmental quality. Lehtinen and Lehtinen (38) also included the third service quality dimension, structure, which was named as physical support. Physical support was a framework enabling or facilitating the production of a service which was divided into the environment and instrument.

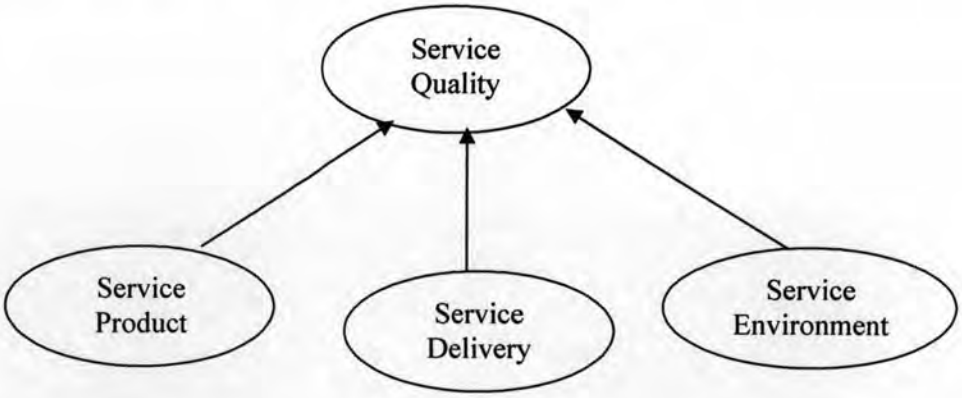

Figure 5 Three service quality dimensions
Source: Rust and Oliver, 1994

Carman (39) indicated that consumers evaluated the technical dimensions of nursing care, physician care, and outcome as more importance than the accommodation functions of hospital care. Technical service quality and functional service quality were also investigated among patents in Taiwan. This reflected that perceived service quality of client compose of both process and outcome quality. (25) Panyawuthikrai (40) had developed instrument to measure perceived service quality of community pharmacy customers in three dimensions; structure, process and outcome. The result confirmed that these dimensions of health service quality were perceived by client.

In summary, structure quality was related to surrounding environment which can influencing perception of the overall quality of the service encounter. Whereas structure quality of health care designated the conditions which care was provided. Structure included material resources such as facilities and equipment; human resources such as the number, variety and qualifications of professional and support personnel; and organizational characteristics such as the organization of the medical and nursing staffs, methods of paying for care and so on. (35)

Process quality was how service was provided to receiver. In health care context, process meant the activities that constitute health care including diagnosis, treatment, rehabilitation, prevention and patient education. Process usually carried out by professional personnel but also including other contributions to care for instance, particularly by patients and their families. (35) The provider-receiver interactions took place during service delivery. Brady and Cronin (37) found that customers perceived attitudes, behaviors and expertise as interaction quality. Therefore, process quality was measured in three subdimensions consisting of attitudes, behaviors and expertise of service provider perceived by client.

The last dimension of service quality, outcome was the result of service production process. It was the relevant feature clients evaluate after service delivery. In providing health care process, outcome meant changes in individuals and population current and future health status that could be attributed to health care. Outcome included (35) changes in health status, changes in knowledge acquired by

patients and family members that may influence future care, changes in the behavior of patients or family members that may influence future health, and satisfaction of patients and their family members with the care received and its outcomes

2. Satisfaction Emotions

It was found that quality judgments were a precursor to the attitudinal formation of satisfaction, therefore judgments of quality were thought as the result of a cognitive process in which consumers compared previous held expectations of service provision with current perceptions of the service provided. (41) However, the cognitive component is not only one element of satisfaction. Another aspect of satisfaction was an affective state that the emotional react to service experience. (42) It was suggested that emotions may distinguish customer satisfaction from service quality. Liljander and Strandvik (43) argued that customer satisfaction included both affective and cognitive components. Customer satisfaction emotions can be divided into two groups consisting of positive emotions and negative emotions. Positive emotion include happy, hopeful and positively surprised, while negative emotions include angry, depressed, guilty and humiliated.

Cronin et al. (44) also recognized that emotion was a core attribute in satisfaction and suggested that customer satisfaction should include a separate emotional component. It was found that emotions had an influence on behavior. A positive emotions tended to link to one decisions to stay or continue with what had been doing and may also led one to share the positive experience with others. Conversely, negative emotions tended to link to the opposite decisions such as to leave or discontinue involvement and may result in complaining behavior. (45) Yu and Dean (46) found that both positive and negative emotions and the cognitive component of satisfaction correlated with loyalty. Positive emotions were indicated as the best predictor of both overall loyalty and the most reliable dimension of loyalty, positive word of mouths.

In Thailand, it was also found that the frequency of positive emotions was the most important predictor of clinical loyalty, followed by the cognitive factor of how

much overall performance exceeded or fell below expectations. The frequency of negative emotions was inversely related to loyalty. (25) White (47) further indicated that the best predictor of loyalty for those in bad mood was service quality followed by negative emotions and then positive emotions while the best predictor of loyalty for those in good mood was positive emotions follow by negative emotions and service quality. However, inclusion of mood along with service quality, positive emotions and negative emotions did not greatly enhance the overall predictive ability of loyalty.

3. Accessibility Factors

Persson and Huang (48) found that personal characteristics, patients' perception to health care service and accessibility sacrifice are associated with patient loyalty attitudes and behaviors. Furthermore, the perception of medical services and accessibility sacrifice were strongly associated with patient loyalty attitudes and behaviors. The results of stepwise multiple linear regression indicate that factors of service outcomes, physician care, distance and costs, chronic disease, labor experience and external issues explain variance of 53.1 percent in loyalty attitudes.

4. Sociodemographic Factors

Patterson indicated that age and occupation were associated with service loyalty across the three industries studied including health care service, while gender was not. (49) In terms of personal characteristics influencing loyalty attitudes and behaviors, Persson and Huang (48) found that all the components of personal characteristics have significant effects on patient loyalty, except for education and sex. They also indicated that factor of chronic disease combined with physician care, labor experience and service outcomes predict variance of 29.7 percent in loyalty behavior. It was indicated that age related to Thai clients loyalty to reproductive health care clinics. Conversely, education was not related to client loyalty. (24) On the other hand, Caruana (16) investigated that both education and age played a major role in determining the different perceptions of customers to loyalty.

III. Primary Care Units

National Health Security Act B.E. 2545 entitles all Thai population to have fundamental right to receive standard and efficiency public health service. Primary care units have been established to provide primary medical care. A primary care units are located in the community covering entitled not more than 10,000. Client can averagely arrive in 30 minutes by car. Operating hours should not less than 56 hour per week and open every day. Services provided at primary care units include curative care, health promotion, disease prevention and rehabilitative care. Primary care unit may provide dental and pharmacy services and/or has a referral system with higher level of health care facilities. (2)

Health staffs providing care at primary care units for entitled not more than 10,000 consist of health personnel as follow:

- 1 physician working as service provider, service quality regulator and consultant
- 2 nurses working as permanent staff
- 3 other graduated health personnel working as permanent staff
- 3 certificated health personnel working as permanent staff
- 1 dentist works not less than 3 hour per week per 1,000 entitled
- 1 pharmacist works not less than 4 hour per week per 1,000 entitled

There are 17 Community Health Center providing primary care services in Muang district, Chonburi province. 4 different types of a physician service were available in 14 Community Health Centers consisting of a physician visit monthly, 2 times per month and weekly. A physician service is not available in the remainder 3 Community Health Centers.