

Customer Participation in Health Care Services: A Proposed Framework for Enhancing Chronic Illness Management



Muhammad Junaid and Kiane Goudarzi

Abstract Customer participation (CP) is a major research area in services marketing. The focus remains on outcomes of CP, mainly in want-based services. The existing literature is limited to answer; what is meaning of CP in need-based services like health care? how CP itself is being affected? and what is role of psychological forces on CP. The mix method research is used to answer these questions. Seventy-five semi structured interviews were conducted with doctors, patients and paramedical staff to conceptualize patient participation and patient education as study constructs besides identifying certain psychological factors in building a conceptual model. Structural equation modeling (SEM) is used to test the model by analyzing survey data of 690 patients of chronic diseases like diabetes, hypertension and cancer. Findings show that patient education has a significant positive impact on participation, patient perceived control and satisfaction. Conceptual fluency mediates relationship between patient education and participation. Doctor's psychological considerations strengthen positive relationship between patient education and conceptual fluency. The study concludes with research directions and policy implications for professionals.

Keywords Patient participation · Conceptual fluency · Perceived control · Psychological considerations · Health care services

M. Junaid (✉)
Aix Marseille Université, Marseille, France
e-mail: muhhammad.junaid@iae-aix.com

K. Goudarzi
Université Jean Moulin Lyon 3, Lyon, France
e-mail: kiane.goudarzi@univ-lyon3.fr

Introduction

The importance of customer participation is well recognized in services literature (Chan et al. 2010; Dellande et al. 2004; Dong and Sivakumar 2017) and also endorsed by health care professional in clinical studies (e.g., Cahill 1995, 1998; Guadagnoli and Ward 1998; McColl-Kennedy et al. 2012, 2017). Although a growing body of literature (Chan et al. 2010; Dong and Sivakumar 2017) highlights the importance of customer participation in services marketing but the understanding of the factors that facilitate participation is not well developed. In the debate of customer participation, a larger focus is found on the outcomes of customer participation and lesser attention is paid on the antecedent of customer participation (Dong and Sivakumar 2017). The role of customer education as an antecedent to customer participation in high credence services like health care is yet to be explored. According to Ostrom et al. (2015) health care provides to scholars an important context for services research. Berry and Bendapudi (2007) also acknowledged health care as a “fertile field for service research”.

The purpose of the study is to present a comprehensive understanding of the concept of “patient participation” and “patient education” in health care services and to explore the impact of psychological patient factors modifying the patient education, patient participation and patient satisfaction chain for health care customers under prolonged treatment. The next section gives a brief review of literature on customer participation.

Customer Participation

“Customer participation refers to the degree to which the customer is involved in producing and delivering the service” (Dabholkar 1990). The growing potential of customer participation has grasped the attention of many researchers from multiple disciplines. The initial work stressed the benefits of involving customers as co-producers or partial employees mostly for customization, productivity gains, quality improvements and so on (e.g., Lovelock and Young 1979; Mills and Morris 1986). On the customer side it was attempted to know when and why customers are motivated to participate (Bateson 1985) and means of facilitating customer participation (Goodwin 1988). The research progressed also from conceptual to empirical investigation to see the effect of customer participation on service outcomes, like satisfaction and loyalty (Auh et al. 2007; Bendapudi and Leone 2003). The scope of research in the last decade even reaches new product development (Fang 2008; Fang et al. 2008), service failure and recovery (Dong et al. 2008).

The Customer participation is a major focus of interest in service research (Chan et al. 2010; Dong and Sivakumar 2017). Service management and marketing scholars have much to offer to a critically important, intellectually challenging, but deeply troubled health care service sector (Berry and Bendapudi 2007). In past few

years, customer participation has emerged as major research subject in health care services (e.g., Berry and Bendapudi 2007; Dellande et al. 2004; Gallan et al. 2013; McColl-Kennedy et al. 2017). The customer participation outside of service organization, which is considered a key requirement of many health services is largely an ignored area in service marketing literature (Dellande et al. 2004). Health care being a complexed service needs higher level of customer participation. Successful management of health particularly in chronic diseases like diabetes, hypertension and cancer is very much dependent on participation of health care customers rather than health care providers. The question arises how the appropriate participation can be made by the customers particularly in complexed services like health care? Although a growing body of literature highlights the importance of customer participation in services marketing but the understanding of the factors that facilitate participation like customer education is less well developed particularly in high credence services like health care. Therefore, this study focus on the role of customer education for desired outcomes in health care services. The literature helped us to identify the following knowledge gaps to be focused:

Research Gaps Customer participation and customer education not comprehensively conceptualized in high credence services like health care.

Customer education as an antecedent of customer participation is not well focused in the services marketing literature particularly in health care services.

The understanding of the psychological factors to facilitate participation is missing in discourse of customer participation.

The later part of the paper is organized in a way that firstly we present the methodology and key findings of our qualitative study to conceptualize patient participation and patient education as the major study constructs. Secondly, we give the conceptual framework and hypotheses developed for empirical testing. Later, methodology and results of quantitative study are presented. The last section discusses the study contributions and limitations followed by future research directions and policy implications for health care professionals and policy makers.

Qualitative Study

The review of literature on customer participation and customer education in services marketing and health care journals revealed that the concepts of customer participation and customer education are complexed and multifactorial and furthermore the literature is very much fragmented. These concepts were defined and operationalized mostly in certain specific contexts or pertaining to only one single encounter or involving a specific stage in service delivery process. This clearly indicates that that efforts are needed to formulate standardized definitions of the concept of patient participation and patient education to build consistent understanding of the concepts and developing reliable and valid measures. The purpose of qualitative study is to get deep down insights on patient participation and to conceptualize in a

comprehensive way the concept of patient education and patient participation in health care services and to identify potential psychological factors playing key role in relationship between patient education and patient participation.

Methodology

The study was conducted using 75 semi structured interviews with doctors (33), patients (30) and paramedical staff (12). An interview guide was prepared following guidelines given by McCracken (1988), literature on customer participation and customer education and incorporating the recommendations from researchers and senior doctors and hospital administration staff. The face to face interviews were mostly conducted in the hospitals and clinics to get more factual data in natural settings. To ensure the diversification and richness of data special efforts were made to interview doctors with different specialization, patient with different diseases and experienced paramedical staff performing diversified tasks in the health care operations at different clinics and hospitals. The hospital includes both from public and private sectors. The doctors were also having experience of serving in different geographical location of Pakistan including urban and rural areas, small and big cities. The patients interviewed were also having diversified diseases with different educational background and professions. Interviews were recorded using an electronic device with the permission of participants. Recoding time range was 15–37 min. Later, interviews were transcribed producing 184 single spaced pages of textual data with 93,021 words. The data was analyzed on the basis of objective of the study and the guidelines for analysis of qualitative data by Bryman (2012). The codes/themes were developed to conceptualize patient participation and patient education using content analysis with mix method approach. The results and finding of the study are presented in next section.

Findings of Qualitative Study

We got lot of interesting findings and results through our qualitative study here we will restrict to our study objectives i.e. the conceptualization of patient participation and patient education along with the potential variable identified for our conceptual model. Patient participation emerged as three-dimensional construct (Table 1) which indicates that patient can participate firstly, by providing and sharing informations to the health care providers, secondly by actively involving in the decision making process and thirdly by ensuring compliance to many of the things required by the health care providers.

Patient education also emerged as three-dimensional construct (Table 2) which indicates that patient education is basically the communication by the doctor focused on the disease and treatment information. *Secondly*, communication

Table 1 Three dimensions of patient participation emerged through qualitative data analysis

Patient participation dimensions	Selected quotes
1. Sharing informations	<p>“In my opinion, patient participation means to help the doctors in explaining the conditions and to convey the history” (RPT30)</p> <p>“First of all, they should give us all the details about their disease including all the signs and symptoms” (RDR18)</p>
2. Involvement in decision making	<p>“So, in the modern practice patient is always involved in decision-making and patient has the right to discuss about her problems in detail and about her management” (RDR25)</p> <p>“These days many surgical procedures could be applied like laparoscopic or open surgery patient decides the final option” (ROT12)</p>
3. Ensuring compliance	<p>“By participation mean patient have to Follow the schedule of visits recommended by doctor” (RDR22)</p> <p>“The patient should have availability on follow-ups visit as advised like visits after certain days or weekly or monthly basis” (RDR31)</p>

Table 2 Three dimensions of patient education emerged through qualitative data analysis

Patient education dimensions	Selected quotes
1. Communication focused on disease and treatment information	<p>“For me it is very important if the patient knows what he is suffering from why he or she is sick, and how the sickness can be handled” (RPT01)</p> <p>“In simple words by educating the patient mean telling the patient about the disease, that what exactly is the disease?” (RDR18)</p>
2. Communication focused on diet and life style modification	<p>“We expect they should be following the diet, certain lifestyle modifications and doing some exercises as well.” (RDR25)</p> <p>“Many diseases which are related to your diet and are related with your lifestyle; we advise patients on lifestyle modification.” (RDR27)</p>
3. Communication focused on negative consequences	<p>“We also tell him about the mishaps with the people who didn’t take their medicine regularly, as per schedule.” (RPT03)</p> <p>“In educating patient, you should tell the patient for example in case of chronic disease what could be the side or bad effects.” (RDR29)</p>

focused on diet and life style modifications and *thirdly* communication focused on negative consequences.

We also identified some potential variables including conceptual fluency, psychological consideration and patient control on illness for inclusion in our empirical model (This paper is brief of PhD dissertation and discussion of these results is beyond the scope of this paper). Our results also show that the chronic diseases need comparatively higher level of patient participation. The 61% (46/75) participants used the words indicating higher participation in their discussion and out of these 46 patients, 96% (44/46) participants related the need of higher participation in case of

chronic diseases like diabetes, hypertension and cancers. This helped us to focus on chronic illnesses only for empirical testing of our model. In the next section we conceptualize our model along with hypothesis development.

Conceptual Framework and Hypotheses

Patient Education and Patient Participation The literature shows that customer education has been considered an important antecedent of active customer participation in service process (Bateson 2002; Lovelock 2011). Patient education improves the participation through better compliance in a broad range of conditions and severity of disease (Gold and McClung 2006). Customer receiving knowledge and skills through education in turn, are willing to reciprocate with participation, so customer education is likely to have a significant effect on customer participation (Eisingerich and Bell 2006). Thus, we hypothesize as:

H1. Patient education will positively impact patient participation.

Conceptual Fluency Conceptual fluency is the ease of processing the meaning of a stimulus, or the fluency of conceptually driven processing (Whittlesea 1993). The conceptual fluency for the current study is described as “the ease with which patients process and understands the instructions given by the health care professionals”. “The Conceptual fluency describes the ease with which customers can process and understand information (Lee and Labroo 2004; Sirianni et al. 2013)”. The patient education in the form of communication by doctor is expected to enhance the conceptual fluency of patients. Thus, we hypothesize as:

H2. Patient education will have significant positive impact on conceptual fluency.

A better comprehension of information developed by the patient relates to higher compliance with the advice given by doctor (Kincey et al. 1975). The increased conceptual fluency of patients will facilitate them in understanding better the instructions and follow them subsequently in an effective way. Thus, we hypothesize as:

H3. Conceptual fluency will mediate the impact of patient education on patient participation.

Patient Control on Illness The nature of chronic diseases is that these cannot be cured completely rather need to be managed or controlled. The chronic illness patients have to control their signs and symptoms and keep track of certain parameters. The patient control is “the patient’s psychosocial adjustment to the illness and perceived competence and control over symptoms, the future course of the disease and medical care” (Ouschan et al. 2006). Health care being a complexed service needs higher level of participation. The patient participation is associated with better health outcomes by empowering the patients to take control of the chronic illness (Michie et al. 2003). Thus:

H4. Patient participation will mediate the impact of patient education on patient control on illness.

Satisfaction with Doctor The treatment of chronic illness mostly involves the services of a medical expert like diabetologist, medical specialist, dermatologist, urologist, oncologist etc. Accordingly, satisfaction is derived from the services provided by the treating doctor. The active customer participation in service process has an impact on the customer satisfaction (Bitner et al. 1997). The patients involved in health care decisions usually get realistic and more appropriate treatments, lesser complaints and, enjoy better sustainable health outcomes and ultimately experience higher satisfaction (Trede and Higgs 2003). Similarly, Dellande et al. (2004) demonstrated that customer compliance (participation) significantly relates to customer satisfaction. Accordingly, we hypothesized as follows:

H5. Patient participation will mediate the impact of patient education on satisfaction with doctor.

Satisfaction with Life Chronic illness conditions create difficulties and limitations for the patients in their daily life. When patients start participating actively in the treatment of these diseases, they find the ways to adjust in their daily life. They live with these chronic conditions and could be satisfied too with the ongoing life. Satisfaction with life is not objective rather it is subjective and vary from person to person. Life satisfaction is based on a cognitive judgmental process (Diener et al. 1985). This shows that perhaps there is no single criteria of life satisfaction. According to Shin and Johnson (1978) life satisfaction is “a global assessment of a person’s quality of life according to his own chosen criteria”. The patients with chronic illness conditions take care of themselves by actively participating in the treatment process. This act of participation gives the patients feeling of performing the activities like persons not handicapped with these chronic illnesses. These patients could find new meaning in their life. This resultantly give them a feeling of leading a satisfied life even with chronic illnesses. Therefore, we hypothesized.

H6. Patient participation will mediate the impact of patient education on satisfaction with life

Doctors Psychological Considerations The health psychology literature highlights the importance of biopsychosocial model to be pursued by the doctor in dealing with the patients. The current biopsychosocial perspective in contrary to biomedical perspective (which considered the disease only a biological disorder) puts more emphasis on doctors to treat the patients with greater empathy, respect and psychological adherence (Sarafino and Smith 2014). If doctors while educating the patients pay greater physiological consideration it will enhance the impact of patient education on their ease of processing the educational input in the form of verbal or oral content. Therefore, we hypothesize as:

H7. Psychological considerations strengths the positive relationship between patient education and conceptual fluency

The next section gives the detail of quantitative study.

Methodology

Measures The measures for satisfaction with doctor (Hausman 2004) and satisfaction with life (Diener et al. 1985) were adopted and measure for conceptual fluency was expanded and rephrased to fit our context as used in Journal of marketing by Sirianni et al. (2013). The measures for Psychological considerations, patient perceived control on illness were developed particularly for the current study based on qualitative findings and existing literature. The measures for patient participation was developed as three-dimensional second order construct with the help of 10 items from existing literature (Chan et al. 2010; Gallan et al. 2013; Hausman 2004) and 13 items are developed through exploration of qualitative work. The measures for patient education was developed as three dimensional second order construct with the help of 11 items from existing literature (Auh et al. 2007; Ouschan et al. 2006; Seiders et al. 2015) and 10 items are developed through exploration of qualitative work (the development of measures was part of PhD thesis and is beyond the scope of current paper).

Data collection Data was collected using survey form circulated through survey monkey and self-administered questionnaires given to patients by visiting different hospital's waiting area in major cities of Pakistan. The patients who were under treatment of a chronic disease for at least more than 6 months were chosen through purposive sampling. Firstly, the researcher got the approval from the senior administration of hospital and specialized clinic of chronic disease through written correspondence or power point presentation in order to recruit the participants. Later, consent was obtained from the individual respondents to participate in the survey. 1150 questionnaires in total were distributed (500 through survey Monkey and 650 self-administered paper printed). Out of these 744 filled surveys were received; 54 incomplete forms were excluded, and 690 responses were available for the data analysis. The distribution is given in Table 3.

Data Analysis Initially data cleaning was performed on SPSS 25 for checking the normality of data. After removing 57 respondents identified as outliers, the remaining normally distributed data of 633 respondents was used to run the final analysis in AMOS 24. Firstly, a measurement model was run using all the study variables of first order and then by adding second order constructs of patient participation and patient education. Trough successive deletion of weak and cross loading of observed variables (items) the model was improved. The final measurement model achieved the maximum fit indices of global criteria ($\chi^2/df = 2.193$, TLI = .946, CFI = .951, RMESA = .043, SRMR = .0429, PCLOSE = 1). The reliability and validity test achieve the threshold values of Cronbach alpha, convergent and discriminant validity (AVE > .5, MSV < AVE) as shown in Table 4. All the HTMT ratios are also less than .85 as shown in Table 5.

Table 3 Disease and gender details of research participants

Demographics	Total	%age
	690	100%
Gender:		
Male	393	56.96%
Female	295	42.75%
Other (Transgender)	2	0.29%
Disease:		
Diabetes	109	15.80%
Hypertension (blood pressure)	88	12.75%
Asthma/COPD	39	5.65%
Hepatitis B/C	23	3.33%
Cancer	53	7.68%
Tuberculosis (TB)	7	1.01%
Skin Disease	73	10.58%
Arthritis/joint pain	63	9.13%
Heart problems	61	8.84%
Stroke	8	1.16%
AIDS (HIV)	2	0.29%
Chronic kidney disease (CKD)	59	8.55%
Allergies	17	2.46%
Others (migraine, disorders, chronic pains)	88	12.75%

Structural Model Later the measurement model in AMOS was converted into structural model by removing all the covariance and connecting the variables using single head arrows as per our hypotheses. Gender impact on patient perceived control on illness was controlled. The final structure model fit also achieved the local and global fit indices ($\chi^2/df = 2.350$, TLI = .937, CFI = .942, RMSEA = .046, SRMR = .0489, PCLOSE = .988) (Fig. 1).

Results and Discussion

The effect of patient education on patient participation ($\beta = .20, \rho < .001$) and conceptual fluency ($\beta = .51, \rho < .001$) is positive and significant, validating H1 and H2. The mediations test was performed in AMOS using Bootstrap sample 5000 with CI 95%. Table 6 shows all the mediations hypotheses (H3, H4, H5, H6) are validated whereas the impact of patient education on satisfaction with life is fully mediated through patient participation.

Table 4 Reliability and validity table

Variable	CB Alpha	CR	AVE	MSV	MaxR(H)	Sat_Dr	Pat_Contrl	C_Fluency	Sat_Life	Pyc_Consid	Pat_Edu	Pat_Part
Sat_Dr	0.954	0.955	0.808	0.527	0.956	0.899						
Pat_Contrl	0.89	0.892	0.673	0.428	0.895	0.573***	0.821					
C_Fluency	0.845	0.859	0.605	0.484	0.868	0.637***	0.562***	0.778				
Sat_Life	0.901	0.903	0.7	0.254	0.912	0.433***	0.441***	0.400***	0.836			
Pyc_Consid	0.911	0.914	0.729	0.61	0.928	0.698***	0.533***	0.547***	0.282***	0.854		
Pat_Edu	0.913	0.903	0.757	0.61	0.946	0.656***	0.514***	0.589***	0.261***	0.781***	0.87	
Pat_Part	0.864	0.815	0.595	0.484	0.818	0.541***	0.526***	0.696***	0.403***	0.492***	0.567***	0.771

*** (p < 0.001)

Table 5 HTMT ratios showing discriminant validity (Threshold for individual values <.85)

	Sat_Dr	Pat_Contrl	C_Fluency	Sat_Life	Pyc_Consid	Com_F_DT	Com_F_DL	Invl_DM	Com_F_NC	Info_Sharing	P_Compl
Sat_Dr											
Pat_Contrl	0.581										
C_Fluency	0.641	0.576									
Sat_Life	0.427	0.444	0.405								
Pyc_Consid	0.724	0.543	0.573	0.291							
Com_F_DT	0.645	0.483	0.572	0.274	0.715						
Com_F_DL	0.607	0.484	0.585	0.24	0.759	0.806					
Invl_DM	0.416	0.438	0.518	0.337	0.452	0.525	0.454				
Com_F_NC	0.482	0.38	0.415	0.167	0.612	0.652	0.808	0.343			
Info_Sharing	0.422	0.35	0.543	0.288	0.367	0.468	0.385	0.671	0.227		
P_Compl	0.447	0.481	0.558	0.323	0.399	0.444	0.404	0.51	0.259	0.631	

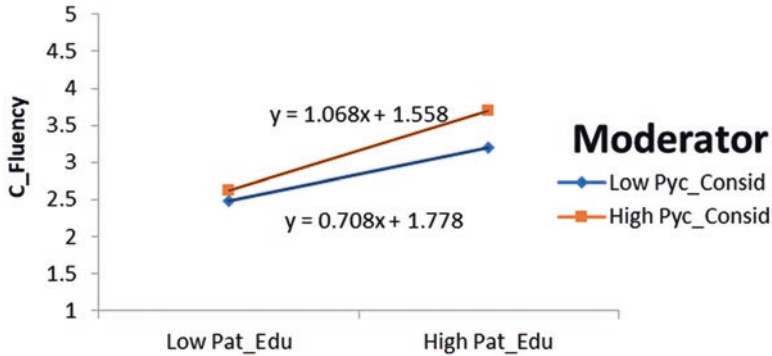


Fig. 2 Moderation effect of Psy_Consideration

Managerial Implications Health care organizations could use the present research in developing training programs for doctors, paramedical and front-line staff for patient education. Irreversible impact of non-participation or wrong participation could be minimized, through proper patient education efforts leading to enhanced patient participation. The mediations results have practical implications for doctors and health care professionals in building satisfaction and patient control on illness.

Limitations and Future Research recommendations Cross sectional data was collected; research should be repeated with longitudinal studies. There could be common method bias as quantitative data was collected for all the variables from same respondent. Objective measures (e.g. biomarkers like blood pressure readings, blood glucose, MRI Image etc.) could be used in experimental studies to investigate the impact of Patient education on patient participation. Some variable like religiosity and emotional support could be included in in future studies as antecedent of patient participation for disease like cancer and kidney failure patients.

References

- Auh, S., Bell, S. J., McLeod, C. S., & Shih, E. (2007). Co-production and customer loyalty in financial services. *Journal of Retailing*, 83(3), 359–370.
- Bateson, J. (2002). Are your customers good enough for your service business? *The Academy of Management Executive*, 16(4), 110–120.
- Bateson, J. E. (1985). Self-service consumer: An exploratory study. *Journal of Retailing*, 49–76.
- Bendapudi, N., & Leone, R. P. (2003). Psychological implications of customer participation in co-production. *Journal of Marketing*, 67(1), 14–28.
- Berry, L. L., & Bendapudi, N. (2007). Health care: A fertile field for service research. *Journal of Service Research*, 10(2), 111–122.
- Bitner, M. J., Faranda, W. T., Hubbert, A. R., & Zeithaml, V. A. (1997). Customer contributions and roles in service delivery. *International Journal of Service Industry Management*, 8(3), 193–205.

- Bryman, A. (2012). *Social Research Methods* (4th ed.) New York: Oxford University Press.
- Cahill, J. (1995). Patient participation. *Journal of Advanced Nursing*, 22(5), 561–571.
- Cahill, J.O. (1998). Patient participation—A review of the literature. *Journal of Clinical Nursing*, 7(2), 119–128.
- Chan, K. W., Yim, C. K., & Lam, S. S. (2010). Is customer participation in value creation a double-edged sword? Evidence from professional financial services across cultures. *Journal of Marketing*, 74(3), 48–64.
- Dabholkar, P. A. (1990). How to improve perceived service quality by increasing customer participation. In Proceedings of the 1990 academy of marketing science (AMS) annual conference (pp. 483–487). Springer, Cham.
- Dellande, S., Gilly, M. C., & Graham, J. L. (2004). Gaining compliance and losing weight: The role of the service provider in health care services. *Journal of Marketing*, 68(3), 78–91.
- Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment*, 49(1), 71–75.
- Dong, B., Evans, K. R., & Zou, S. (2008). The effects of customer participation in co-created service recovery. *Journal of the Academy of Marketing Science*, 36(1), 123–137.
- Dong, B., & Sivakumar, K. (2017). Customer participation in services: Domain, scope, and boundaries. *Journal of the Academy of Marketing Science*, 45(6), 944–965.
- Eisingerich, A. B., & Bell, S. J. (2006). Relationship marketing in the financial services industry: The importance of customer education, participation and problem management for customer loyalty. *Journal of Financial Services Marketing*, 10(4), 86–97.
- Fang, E. (2008). Customer participation and the trade-off between new product innovativeness and speed to market. *Journal of Marketing*, 72(4), 90–104.
- Fang, E., Palmatier, R. W., & Evans, K. R. (2008). Influence of customer participation on creating and sharing of new product value. *Journal of the Academy of Marketing Science*, 36(3), 322–336.
- Gallan, A. S., Jarvis, C. B., Brown, S. W., & Bitner, M. J. (2013). Customer positivity and participation in services: An empirical test in a health care context. *Journal of the Academy of Marketing Science*, 41(3), 338–356.
- Gold, D. T., & McClung, B. (2006). Approaches to patient education: Emphasizing the long-term value of compliance and persistence. *The American Journal of Medicine*, 119(4), S32–S37.
- Goodwin, C. (1988). “I can do it myself:” training the service consumer to contribute to service productivity. *Journal of Services Marketing*, 2(4), 71–78.
- Guadagnoli, E., & Ward, P. (1998). Patient participation in decision-making. *Social Science & Medicine*, 47(3), 329–339.
- Hausman, A. (2004). Modeling the patient-physician service encounter: Improving patient outcomes. *Journal of the Academy of Marketing Science*, 32(4), 403–417.
- Kincey, J., Bradshaw, P., & Ley, P. (1975). Patients’ satisfaction and reported acceptance of advice in general practice. *JR Coll Gen Pract*, 25(157), 558–566.
- Lee, M. P., Yoon, C., & Mitchell, A. A. (2004). *Perceptual and conceptual fluency as antecedents of the mere exposure effect*. School of Business, Singapore Management University.
- Lovelock, C. (2011). *Services Marketing, 7/e*. Pearson Education India.
- Lovelock, C. H., & Young, R. F. (1979). Look to consumers to increase productivity. *Harvard Business Review*, 57(3), 168–178.
- McCull-Kennedy, J. R., Snyder, H., Elg, M., Witell, L., Helkkula, A., Hogan, S. J., & Anderson, L. (2017). The changing role of the health care customer: Review, synthesis and research agenda. *Journal of Service Management*, 28(1), 2–33.
- McCull-Kennedy, J. R., Vargo, S. L., Dagger, T. S., Sweeney, J. C., & van Kasteren, Y. (2012). Health care customer value cocreation practice styles. *Journal of Service Research*, 15(4), 370–389.
- McCracken, G. (1988). *The long interview* (Vol. 13). Sage.
- Michie, S., Miles, J., & Weinman, J. (2003). Patient-centredness in chronic illness: What is it and does it matter? *Patient Education and Counseling*, 51(3), 197–206.

- Mills, P. K., & Morris, J. H. (1986). Clients as “partial” employees of service organizations: Role development in client participation. *Academy of Management Review*, *11*(4), 726–735.
- Ostrom, A. L., Parasuraman, A., Bowen, D. E., Patricio, L., & Voss, C. A. (2015). Service research priorities in a rapidly changing context. *Journal of Service Research*, *18*(2), 127–159.
- Ouschan, R., Sweeney, J., & Johnson, L. (2006). Customer empowerment and relationship outcomes in healthcare consultations. *European Journal of Marketing*, *40*(9/10), 1068–1086.
- Sarafino, E. P., & Smith, T. W. (2014). *Health psychology: Biopsychosocial interactions*. John Wiley & Sons.
- Seiders, K., Flynn, A. G., Berry, L. L., & Haws, K. L. (2015). Motivating customers to adhere to expert advice in professional services: A medical service context. *Journal of Service Research*, *18*(1), 39–58.
- Shin, D. C., & Johnson, D. M. (1978). Avowed happiness as an overall assessment of the quality of life. *Social Indicators Research*, *5*(1–4), 475–492.
- Sirianni, N. J., Bitner, M. J., Brown, S. W., & Mandel, N. (2013). Branded service encounters: Strategically aligning employee behavior with the brand positioning. *Journal of Marketing*, *77*(6), 108–123.
- Trede, F., & Higgs, J. (2003). Re-framing the clinician’s role in collaborative clinical decision making Re-thinking practice knowledge and the notion of clinician–patient relationships. *Learning in Health and Social Care*, *2*(2), 66–73.
- Whittlesea, B. W. (1993). Illusions of familiarity. *Journal of Experimental Psychology: Learning, Memory, and Cognition*, *19*(6), 1235.