TRANSFORMATIVE/HEALTH SERVICES/
PUBLIC AND NON-PROFIT SERVICES

33. CLOCKING HEALTHCARE PROFESSIONALS: INSTITUTIONAL, EMPLOYMENT, AND PERSONAL INFLUENCES

Iris Vilnai-Yavetz\(^1\), Anat Rafaeli\(^2\), Moran Druker\(^2\), Chen Shapira\(^3\)

\(^1\)Ruppin Academic Center, Israel; \(^2\)The Technion, Israel; \(^3\)Carmel Medical Center, Israel

**Purpose:** Since August 2012 Israeli hospital doctors are required to punch time clocks, a requirement rarely enforced for physicians. We examined reactions to time clocks among hospital doctors and assess the relationship of reactions to types of hospitals, employment arrangement, and personal characteristics.

**Methodology:** 676 doctors from 42 hospitals reported their reactions to the clock and to hospital management as well as their institutional (e.g., type and size of hospital), employment (e.g., part time/full time), and personal situation (e.g., gender, age). A two-step cluster analysis segmented doctors by these variables, and allowed assessment of reactions to the clock, management, and medical work by members of different segments.

**Findings:** There were two clusters of doctors in terms of institutional characteristics, and significantly more negative reactions toward clocking in the cluster of large, intensive care hospitals than in the cluster of mid-scale, service hospitals; in the first cluster (large, intensive care hospitals) clocks were viewed as more offensive to physician status, and management as more unfair, cynical, and alienating than in the second (mid-size, service care). Clusters in terms of employment characteristics and in terms of personal characteristics mostly did not relate to physician attitudes toward clocks or management. Physicians generally viewed the clock as demeaning, but in spite of the clock reported a high sense of calling to professional medical service and a weak level of intent to leave hospital work.

**Practical implications:** Professional service providers such as doctors, especially when working in large, acute care hospitals, view time clocks as demeaning, but negative reactions to clocks do not influence professional commitment of service professionals such as physicians.

**Originality/value:** The analyses show that professionalism (an identity and commitment typical to physicians and representative of other professionals) does not mean obliviousness to external control measures such as time clocks, but does mean that such measures do not intrude into one's work. The institutional context in which professionals are employed, however, determines the extent to which professionalism overcomes resistance to control.

****
72. AN EXTENDED CONCEPTUAL FRAMEWORK FOR TRANSFORMATIVE SERVICE RESEARCH

Margeret Hall¹, Christian Haas¹, Steven O. Kimbrough², and Christof Weinhardt¹

¹Karlsruhe Service Research Institute, ²The Wharton School, University of Pennsylvania

INTRODUCTION: TRANSFORMATIVE SERVICE AND WELL-BEING

Transformative service research (TSR), a recently-envisioned branch of service science, is about understanding connections between service offerings and well-being. It has at the core of its conceptualization the goal of improving the well-being of individuals. A founding statement characterizes TSR as: “the integration of consumer and service research that centers on creating uplifting changes and improvements in the well-being of consumer entities: individuals (consumers and employees), communities and the ecosystem” (Anderson et al. 2013). It is also clear that service touches innumerable aspects of daily life. It is then natural that the field of service science explores mitigation of negative and enhancement of positive service experiences beyond the value co-creation and customer satisfaction paradigms. This is well summed up in the conversation between the switch from goods-dominant to service-dominant logic (Vargo et al. 2008).

Currently the TSR agenda is lacking a measurement tool which considers the foundational structure of how well- and ill-being implant itself into service-oriented society. In order to use well-being as a societal indicator, that indicator must first be delineated in a way that is reliable and replicable. Mapping well-being, or its negatively correlated partner ill-being, is not such an imminently achievable task. Well-being is per definition highly subjective, multi-dimensional, dynamic, and at best fuzzily defined. As noted by White and Pettit it is important to recognize that the concept under discussion is normative – that well-being and its assessment are inevitably based on values and judgment. This wellness is attributed to states – ‘being’ in terms of material endowments, psychological attributes, and subjective assessments of the personal and environment one exists in (White and Pettit, 2004). The hesitance to design services and policies around such a capricious topic is not hard to understand (Ahn et al. 2011).

In order to move the transformative service research agenda forward, we argue for an extension to the existing framework of (Anderson et. al 2013) which captures the intersection between service and well-being of individuals, communities, and the ecosystem. Our paper is structured to support this approach. We conclude with a discussion of the implications and future research.

CONSUMER-SIDED SERVICES FOR INCREASING WELL-BEING

Services are pervasive. As services and service provision becomes ubiquitous, researchers are increasingly looking at the role of service relationships from the perspectives of provision, perception, and impact. This implies that both macro- and micro-aspects of provision are in effect. Vargo’s 2009 paper on service relationships and service-dominant logic makes this case, writing:

“Thus, value creation through service provision and service exchange relationships at the micro level must be understood in the context of value creation through service provision and service exchange relationships at the macro level. The elements are value, relationships, and networks; the driving force, and thus the nature of value, relationships, and networks, is mutual service provision for mutual wellbeing (Vargo 2009 p. 378).”

Service science in turn can be characterized generally as “an emerging interdisciplinary field of inquiry that focuses on fundamental science, models, theories, and applications to drive service innovation, competition, and well-being through co-creation of value” (Ostrom et al. 2010a p5). Likewise, service science can be looked at as systems of relationships between providers, consumers, and targets. Often, providers and consumers co-create value, with each party taking ownership over its assigned dimensions. This creates a complete service cycle in which co-creation leads to co-created value (Spohrer and Maglio 2010). Whereas goods-dominant logic focuses on tangible and productive goods, service-dominant logic is a scientific process looking at value-in-use as created in and by service systems and design (Spohrer et al. 2008; Vargo et al. 2008). Specifically, we consider service design as the design of service symbols, things, interactions, and environments (Buchanan 2001).

Service design is transformative when it has a measurable, even optimizing, positive affect on well-being. Within the service-dominant logic paradigm, this is a worthy target; moreover, well-being’s positive
economic and societal outcomes have been scientifically proven in works of (Spohrer et al. 2008; Berry et al., 2005; Diener et al. 1999; Diener & Chan 2010). As such, TSR is an exciting approach: irrespective of domain, it offers the prospect of well-being outcomes like enabled or increased access, social justice, agency, and ecological stability (Rosenbaum et al. 2011). Both the end goal and the measurement of success are consumer well-being.

TSR was borne out of the recognition of the importance of services to both the global economy and individuals’ daily life. Uplifting changes and improvements refer to design changes in service provision which are conducive to a “better” life. It is increasingly clear that rapid technological changes and the global economic changeover to a service economy has changed how people live (Stiglitz et al. 2010). This becomes especially important considering that by 2050 it is estimated that the world’s population will approach nine billion. An estimated one million people move into cities daily. Researchers and policy makers need to define and measure readiness to provide (well) for the next two billion people. This is no small task when the current seven billion are unevenly serviced. It is with this in mind that the TSR agenda was created. A TSR framework has a fundamental role in developing this approach by taking both provider commitments and consumer well-being into consideration (Rosenbaum et al. 2011), creating service design that enables well-being.

**A Transformative Service Framework**

We propose an expansion to the 2013 TSR framework of Anderson et al. that transforms delicate strands of psychological-emotional states, environmental factors, and personal observations into a service design assessment which is at once reflective and transformative. We utilize a systems approach, meaning the entirety of the service environment needs to be considered in order to assure success (Spohrer & Maglio 2010). In addition to Anderson et al.’s macro-level factors, it adds meso- and micro-level environmental factors. These are generally considered external to service design, service influence defined as a cycle of provision, perception, and impact, and well-being outcomes (Figure 1). Our layered approach allows for analysis of the granularity of daily life; by extending the model with these dimensions, researchers are able to suitably analyze the often compounded aspects of ill-being.

**Figure 1.** A transformative service design framework, adapted from Anderson et al. 2013

This supports our argument that a fundamental reference point for personal and collective assessment of well-being lies in the greater social system (Stiglitz et al. 2010; White and Pettit 2004). This then must include macro-level assessments like access to political freedoms, general peace and stability, equity and overall development (Anand & Sen 1994) and the meso-level of external frame of reference; i.e., how one perceives their place in society (White & Pettit 2004). Here one finds objective measurements like social hierarchy and minority status, as well as less standard measures like “life chances” one has had, and the
general prestige of their life circumstances (Veenhoven & Jonkers 1984; Veenhoven 2013). In our framework, the micro-level of consumer-service interaction is the psychological profile of the individual. It is well-established that one’s baseline psychological profile affects the way one subjectively understands their circumstances overall (Schwartz et al. 2002; Purvis et al. 2011; Hall et al. 2013).

The affected domains referenced in Figure 1 have a strong correspondence with macro-, meso-, and micro-environmental factors. Things to consider in transformative service provision include access equity, integration, values, service entity, sector and overall inclusiveness (Anderson et al. 2013; Gebauer & Reynoso 2013). Perception of service provision is driven by a combination of individual and collective understanding of personality traits, family status, perceived control, personal relationships, previous experiences, convictions, and general “wants” balanced by the demands of reality (Veenhoven & Jockers 1984). The optimal impact domains are those such as employment, subjective well-being, activity level, health, education, and integration (Anderson et al., 2013; Rosenbaum et al., 2011). When service design incorporates these aspects, the resulting effect should be an increased consumer well-being.

**The outer circle: Macro level influences on well-being**

Within a secure, participatory democracy there are fewer chances for wide disparity levels between subgroups. This implies that each member of society has access, or a reasonable expectation to be able to participate, affording minorities and other subpopulations the chance of equal servicing. This is generally not true for opaque or authoritarian systems: such governments are less likely to be stable and more likely to provision services along partisan, ethnic or religious lines. Not only are groups unequally serviced, but quality of life overall drops with respect to expected welfare maintenance (Muller 2011). Changes in the overall well-being of the state are driven from the aggregate number of citizens in the state and their access to (civil) services, reflecting the view that progress is contingent to the impacts on and richness of the human life, rather than merely economic advances (Stiglitz et al. 2010; Buchanan 2001). Data gained from instruments like the General Social Survey, World Values Survey or other large publically accessible sets such as that provided by the World Bank DataBank can be utilized in this level.

**Meso-level analysis: the role of the self in the community**

As noted in Ozanne and Anderson (2010), individuals, structural issues, and the socioeconomic context of a given area must be taken into consideration when completing impact assessments. Knowledge of the preexisting conditions and self-assessed roles of a given consumer group is necessary when designing and implementing services to increase communal well-being and/or decrease communal ill-being (Saactcioglu & Ozanna 2013). Well-being is not only access and psychological health, but the perception of one’s place within the greater environment. Individual well-being is intrinsically linked to the individual’s perception of belonging in a community, and their relative status within it. These singular assessments aggregate up to communal well-being. This is to say, in areas where high individual well-being exists, there tends to be high communal well-being. In areas of compounded disadvantage, well-being and its related outcomes tends to be low. This is confirmed in the Framingham Heart Study: high and low well-being networks tend to be clustered within three degrees of separation from one another (Fowler & Christakis 2008).

Our proposed meso-level environment for transformative service design is closely aligned to George Vaillant’s finding on the antecedents of flourishing from the Harvard Grant Study, to date the longest running longitudinal sociological study. He writes that formative experiences are crucial to future health and happiness; the presence of positive relationships matter for happiness; the risks one takes with their lives (e.g. drug and alcohol consumption) have high prediction abilities on one’s ability to maintain family and social relationships (Vaillant 2008). Meso-level analysis is not foreign to the TSR agenda: quoting (Ostrom et al. 2012), TSR considers “…the disparity in the quality of service offerings to different groups, the design and cocreation of services with consumers that honors both the agency and the cultural values of individuals and communities, … (p9)”, which require an understanding of the person and their understanding of belongingness in their community. Longitudinal surveys, panels, and various forms of network analysis can establish the indicators of the meso-level.

**Me, myself and I: Psychological profiles and well-being**

As mentioned earlier, an important factor in well-being is the baseline psychological profile of the person. Considering psychological profile is of utmost importance when measuring service perception as shown in Figure 1, as it is well-established that different personality types report satisfaction and happiness with difference reference points. Confirmed in multiple studies, psychological factors like low(er) needs for circumstance maximization, psychological needs satisfaction, personal goal progress, high self-esteem, and a
positive Big Five Inventory profile are prerequisites for high well-being (John et al. 1991; Schwartz et al. 2002; Purvis et al. 2011; Hall et al. 2013; Sheldon and Hoon 2013).

Maximization refers to one’s ability to be happy with a decision once it has been met. The more one “maximizes” a decision-making scenario, the less happy one is in the long term, ‘the paradox of choice’ (Schwartz et al., 2002). Considering psychological needs satisfaction, Sheldon and Hoon (2013) modeled optimal human well-being with a hierarchical regression analysis, finding that there are four tiers of personality which are predictors of wellness. Their work shows that social relations, self-narratives, goals and life intension, personality traits, and psychological needs are all necessary for high well-being. The Big Five personality factors are the most well-known and widest used personality models in psychology, human resources, and a plethora of other institutions (John et al. 1991). A well-being inducing or positive Big Five profile here is considered to be low neuroticism, high extraversion, and a combination of optimism, agreeableness, conscientiousness (Purvis et al. 2011; Hall et al. 2013; Sheldon & Hoon 2013). Possible research designs for establishing this level include ethnographies and psychometric surveys.

**DISCUSSION AND CONCLUSION**

TSR aims at improving well-being in connection with provision of services. Movement towards this goal requires, among many other things, (1) identifying and understanding the measurable variables that affect well-being in conjunction to the service experience, and (2) obtaining said data. In this paper we have sought to address this by proposing an extended methodology for the configuration and measurement of these variables. We conclude with a few brief remarks on these topics.

We argue that rather than creating new indicators, repurposing available data sets allows TSR researchers to focus on the central concept: designing uplifting service provision and experiences to touch all customers in the pyramid, especially those at the base. An obvious and important use of currently existing data sources is to have them serve as benchmarks for TSR studies. There are two such modes of use. The first is for validating new instruments to be developed by TSR scholars. Existing questionnaires and other instruments, as well as the data collected with them can be used in designing new instruments and in testing them. A second valuable role of these data is to serve as comparison points for studies done at smaller institutions or regions, e.g., clients of a given service agency. Very often, we imagine, targets of TSR will be particular institutions (government agencies, commercial firms, NGOs, etc.) that are on much smaller scale than the most widely-used surveys. Data targeted at a particular institution will be able to compare the effect of the institution against that of the larger society, or in the formalization of value co-creation between providers and consumers ‘at the bottom of the pyramid’. Building on a wealth of existing knowledge and attending to new developments, TSR is poised to contribute enormously to fostering well-being.

**Limitations and future work**

There are limitations to be addressed with this approach. The framework requires measurement tools from which to gauge success - an integrated study which combines the use of our framework and appropriate measurement functions applied to actual data is needed. Although service design and acceptance, and personality factor have been researched, until now our suggested configuration has not been researched. This suggests room for an extended user acceptance test. Finally, what are the missing variables? Literally thousands of variables pertaining to well-being exist. Identifying the lacunae has to be judged an important priority for TSR research.

**REFERENCES**


92. EFFECT OF SERVICE BRAND DIMENSIONS ON BRAND LOYALTY: AN APPLICATION ON WELLNESS SERVICES

**Athanasiou Krystallis**1, Giorgos Kipreos2 and Polymers Chrysochou1

1Aarhus University, Denmark, 2University of Peloponnese, Greece

**Purpose:** The present paper uses a modified version of the Service Brand Verdict (SBV) model proposed by Grace and O’Cass (2005), aiming to investigate the relationship between consumers and service brands. The objective of the study is to test the generalizability of previous findings stemming from the use of the SBV model in different service sectors and cultural settings.

**Methodology:** With the objective to test the generalizability of previous findings stemming from the use of the SBV model in different service sectors and cultural settings, a study was conducted in Greece in two different branded transformative service industries (fitness and body care centers), both with very consistent results.

**Findings:** Previous findings suggesting that brand evidence significantly influences consumer satisfaction, attitude and behavioral loyalty towards service brands were confirmed. Moreover, contrary to previous findings, controlled communication elements (i.e. advertising and promotions) did not have any influence on customer satisfaction with service brands. However, the same communication elements directly and significantly shaped customers’ perceptions of the various brand dimensions and their overall attitude towards the brand. Given the experiential (during-usage) nature of those attributes, the importance of controlled communications in shaping customer perceptions is very high, since their impact can be exercised in a pre-purchase phase, thus preparing the ground for a more positive evaluation of the service brand during usage.

**Originality:** This work validates a modified version of the Service Brand Verdict (SBV) model proposed by Grace and O’Cass (2005) to shed light on how an otherwise established model ‘behaves’, namely whether it can be considered globally valid in its entity, or it has to be tailored to fit to specific contextual conditions. Further, the concept of loyalty is incorporated in the modified SBV model, since loyalty has received broad attention in the service industries, frequently seen as the ultimate determinant for a successful and profitable business.
121. THE KEY SERVICE FACTORS FOR HEALTHCARE KNOWLEDGE DIFFUSION

Ahmed Toufiq\(^1\) and Kunio Shirahada\(^1\)

\(^1\) Japan Advanced Institute of Science and Technology, JAPAN

**Purpose:** One of the major problems at the Base of Pyramid (BoP) is related to human health. To diffuse healthcare knowledge, several methods have been implemented to reach the BoP populations in order to build awareness and to eliminate healthcare disparities such as access to the healthcare services to poor people in the rural community. An Bangladeshi NGO, Bangladesh Rural Advancement Committee (BRAC) is highly praised for promoting and diffusing healthcare knowledge among the poor households through “Shasthya Sebika” in Bangladesh. “Shasthya Sebika” – a woman who is a member of village organization of microcredit system and works at BRAC as a service provider to diffuse basic healthcare knowledge in the rural communities in Bangladesh. This paper examines how the “Shasthya Sebika” makes success to diffuse healthcare knowledge to local communities in Bangladesh through their services activities.

**Approach:** We conduct a qualitative research as a case study of BRAC healthcare program to undo the process of healthcare knowledge diffusion. We conducted interview for 20 Shasthya Sebika about their way of work including knowledge co-creation with local patients and local people.

**Findings:** As an unique study of “Shasthya Sebika” from the view point of knowledge diffusion could have a major role to diffuse healthcare knowledge to the rural community that resulted to make a healthy society and as well as human well-being. Beyond the successful story of “Shasthya Sebika” have several factors such as communication capability, knowledge on healthcare, micro credit impact, socio-economic factors, diffusion channel, and strengthens of village organization influence to make success.

**Originality:** Research on healthcare knowledge diffusion is still remarkably scarce in service research. Focusing on “Shasthya Sebika” as the unit of analysis for healthcare knowledge diffusion in BoP is a new perspective for social innovation.

*****

122. THE ROLE OF OTHER PEOPLE AND EMOTION FOR BLOOD DONATION: AN ALTRUSTIC SOCIAL SERVICE

Rebekah Russell-Bennett\(^1\), Kay Russell\(^2\), Josephine Previte\(^3\), Charmaine Glavas\(^4\), Charmine Hartel\(^3\) and Geoff Smith\(^4\)

\(^1\) Queensland University of Technology, \(^2\)Gold Link Marketing Pty Ltd, \(^3\)University of Queensland, \(^4\)Australian Red Cross Blood Service

**INTRODUCTION**

Blood donation is a critical part of health services with a viable blood supply underpinning an effective health program in any country. Typically blood is provided by voluntary donations from citizens and is therefore reliant on the goodwill and altruistic commitment of donors. In Australia, like many other developed nations, there are many challenges in maintaining a sufficient and sustainable blood supply. The Australian Red Cross Blood Service Donor and Community research group aim is to understand the barriers, motivations and perceptions of donors. Blood donation is a ‘people-processing’ service (Lovelock 1983, Russell-Bennett et al 2013) with the marketing exchange relating to bodily fluid rather than money and is an altruistic social service that has no direct benefit for the customer donor rather the benefit is for other people and society (Kotler and Zaltman 1971). Emotion has been shown to be a motivator and a barrier in a variety of Blood Service studies, this is a key insight that is further explored in the current study. Other key social
factors that impact blood donor behavior are classified as social because they involve perceptions of other people’s beliefs and responses (such as moral or subjective norms), peer pressure, other people’s expectations and other people as a form of support. Given that emotions are social phenomena (Parkinson 1996), this study focuses on the role of other people in the blood donation process and how other people relates to the emotional experience of blood donors. We argue in this paper that overcoming emotional barriers to blood donation by leveraging the role of other people will influence low donation rates in Australia. To date, there has been little evidence in service research that identifies how other people influence customers in a people-processing service where aspects of the body the basis of exchange. In this paper we explore how other people influence the emotional experience of donors and how, donor emotions create the need for other people as a coping resource.

THEORETICAL FRAMEWORK

While prior service research identifies that other people influence customers through emotional contagion, communication and information, they do not adequately explain how this occurs. Given emotions such as anxiety and fear are a barrier for blood donation (Masser et al 2009) and social support is a motivator (Russell-Bennett et al 2013), the two theoretical frameworks being used in this study are affect-as-information theory (Clore, Schwartz and Conway 1994) and social support from coping theory (Vitaliano et al 1985). Affect-as-information theory posits that human behavior results from the information we gain from our feelings, moods and emotions. Emotions are created by the presence, reactions, and behaviors of other people (Parkinson 1996), and emotions influence the creation of judgments and decisions (such as whether to donate or not). Therefore if the Blood Service seeks to influence donor decisions, understanding the impact of other people on these emotions may provide the basis for future service marketing planning. The cognitive appraisal view of emotions (Lazarus and Folkman 1984) depicts emotions giving rise to coping responses, which in turn lead to responses that influence attitudes and behaviors. Coping can be classified into four categories, problem-solving, avoidance, blame and social support (Vitaliano et al 1985) and it is the fourth category whereby other people become involved. Social support is potentially an important factor in influencing donor emotions as it can provide a buffer against the effects of stress (Cohen and Wills 1985).

METHOD

The study employed a qualitative approach using focus groups to identify donor behaviors and motivators at three different stages of donor experience. Specifically, 9 focus groups with Australian donors were conducted with a total of 87 participants. The donors were drawn from two capital cities in Australia (Melbourne and Brisbane), included novice (one donation), experienced (2 + donations) and lapsed donors (no donations in past two years), were mainly female (63%), well-educated and had a mean age of 35 years. The methodological recommendations of Kitzinger and Barbour (1999) were followed in conducting and analyzing the research. During interview data collection, critical Incident Technique was used to identify best and worst donor experiences. To obtain responses to each phase, Day Reconstruction Method was used (DRM) where participants play back in their mind (like a movie) the activities and emotional experiences of a day in the past (Kahneman, Krueger, Schkade, Schwarz, and Stone; 2004). The DRM has a close correspondence with established results from experience sampling with the advantage of lower respondent burden. To synthesize the data a combined technique of inductive and deductive thematic analysis (Fereday & Muir-Cochrane, 2006) was used to analyze focus group transcripts. Multiple coders were used which facilitated an iterative and reflexive refinement of codes identified.

RESULTS

Four main themes arose from the data indicating how other people influence donor behavior: social support, social norms, personal connection and recognition/reinforcement.

Social Support

Social support can occur in four ways; emotional (empathy, encouragement), informational (advice, tips, guidance), tangible (financial assistance, material goods, services) or companionship (physical or virtual presence of others at the service experience) (Wills 1991). The type and source of social support varies based on the donor career stage (novice, experience or lapsed) or by the age of the donor. While novice donors were typically also younger donors, in our sample there were novice donors who were older than 30 and experienced donors under 25. Two types of support sources were identified; personal (peer, workplace or family) and professional (medical and Blood Service staff). Social support was required more by younger and novice donors than by experienced and older donors.
Emotional support was typically required by novice donors regardless of their age. The heightened sense of negative emotions such as fear and anxiety was related to the lack of personal experience. “I wasn’t sure what was going to happen, I’d never done it before and the person I was going with hadn’t done it either so we were both a bit nervous and somewhat afraid I guess” (Male Novice donor, aged 22). As the blood service does not show images or videos of the donation process itself as part of the marketing material there is a level of mystery surrounding the exact process. This lack of certainty creates fear in novice donors and they turn to other people for emotional support such as empathy to cope and manage these emotions. Professional rather than personal sources of emotional support were expressed by novice donors as shown in this quote: Professional rather than personal sources of emotional support were expressed by donors as shown in this quote: ‘the staff member came out but then I had another staff member who reassured me a bit more and they were nicer and friendlier so it really does come down the staff members’ (Female, experienced donor, Aged 31). Blood donation appears to be a private rather than public behavior, particularly for experienced donors whereby few people talk about it. Donors do not always know who the blood donors are in their social networks. This is consistent with prior research that identifies donation as a “private and anonymous way of giving some help to society” (Suarez et al 2004). This may explain why novice donors seek emotional support from professionals rather than personal sources: ‘None of my friends really talked about [donating].’ (Female Novice donor, aged 23).

Tangible support received few mentions and seemed to be limited to transport assistance and the food supplied post-donation as part of the recovery process. Younger donors made mention of the importance of the quality of food post-donation while older donors identified the provision of buses by their workplace or the Blood Service as an important support mechanism: ‘...yeah it wasn’t too bad, I thought it was good because you got to eat cookies and stuff and you get little freebies at the end’ (Female Novice donor, aged 23), ‘Work organized [the donation]... They actually pay for a taxi to pick us up and drop us off’ (Female Novice donor, aged 56) and ‘We got a bus. The blood bank send a bus.’ (Female Novice donor, aged 57).

Informational support in the form of tips and advice about the process are sourced almost entirely from professional sources. The Blood Service website is a primary source of information, possibly due to credibility and a lack of knowledge of personal contacts knowledgeable on blood donation. Interestingly there was considerable criticism of the website which was noted to be difficult to navigate and contained insufficient information. Only a few of the participants used their online social networks through Facebook, twitter, YouTube or forums to find information. Typically, informational support was sought by younger donors to make appointments and determine eligibility criteria: ‘All the information is [on the website]...everything you know like...it’s good that you know the place where you can go...the nearest place...if don’t understand you can go online and book so it’s quite convenient.’ (Male Non-donor, aged 23) and ‘...Overall the information [on the website] is quite interactive, meaning that you know where the nearest center is, that you can get the information you need. It’s very informative information.’ (Male Non-donor, aged 29).

Companionship support, which consists of other people accompanying the donor, was used by younger donors. This may be due to group events and activities playing a larger role in younger people’s lives than older donors who have more commitments on their time. Older donors indicated that they disliked going to the blood service in groups unless it was during work hours in which case going with work colleagues was fine. Typically, companionship support was provided by personal sources such as friends, family or colleagues: ‘there were a few other people donating blood which sort of felt...you felt like you belonged to something, like you helping out….. My work colleagues were very supportive and there seemed to be lots of things going on as well, like some people were eating at the cafe, some people were going in and out of health rooms for health checks.’ (Female Novice donor, aged 27) and ‘I’ve only donated once and that was last year. A friend of mine... we’d both decided by ourselves and we just happened to mention that we were both thinking about so we booked in together and we went down together and did it in our lunch break...it was pretty good. I was a bit daunting at first. I was a bit concerned mostly about how long it was going to take really but I was a bit worried you know of the needles and the clinical setting but I didn’t mind it.’ (Male Novice donor, aged 22).

The four aspects of social support were not discrete, with some social support types co-occurring. For
example, tangible support and companionship were accessed jointly through the use of a shared taxi with work colleagues: ‘I actually went with a group of work mates…..We had a laugh in the taxi on the way home. It was my first time, I was the one they all had to wait for and they were great about it…’ (Female Novice donor, aged 45).

Social Norms
There are two types of norms; descriptive (concerned with what people actually do) and injunctive (concerned with what people think or feel is right) (Cialdini and Goldstein 2004). Given that only around 1 in 30 Australians donate blood and that many people seem unaware of friends or family who donate blood, it was not surprising that injunctive norms rather than descriptive norms motivate people to donate. Additionally, feeling that they were following a higher moral code was expressed through some participants’ expression of positive emotions, such as happiness and pride, as shown in these quotes: ‘I just felt you know fulfilled that I’d done the right thing and I felt happy really and pretty proud in a way.’ (Male Novice donor, aged 22) and ‘I feel pride because I’m actually doing something to help people in the community and doing something positive… Same as happy, you [feel] kind of happy and pleased that you’ve done the right thing, you’ve gone and made the time to do it.’ (Male Experienced donor, aged 27).

According to the norm activation model (Schwartz 1977), norms generate other-oriented emotions such as guilt and pride. Guilt, shame, pride and happiness were emotions that were mentioned by the sample as drivers of their decision to give blood. In particular guilt could operate as a barrier, or a motivator as illustrated in the following quotes: ‘If I can’t give blood I don’t want to be made to feel guilty about it either. So that put me off for a little bit’ (Female Novice donor, aged 29) and ‘Well once you donate you don’t feel it anymore until you know the months go by and you realize that haven’t donated in a while, you feel guilty, you feel anxious…’ (Female Novice donor, aged 24) and ‘Having gone with a bunch of school girls I felt that you didn’t feel alone .I feel it’s still a personalized experience, that this is your blood that is pumping around your body so it’s very personalized in that manner,’ (Female Novice donor, aged 29).

When donors mentioned other people as a source of a descriptive norm, it was usually a family member or close friend as shown in this quote: ‘I was feeling so nervous because I take blood all the time and I didn’t want the needle and then after I actually had the needle I was fine… I just relaxed as soon as the sting was over. I was thinking about my grandpa and thinking about my friend and I think the other thing too was I was watching other people that were obviously regular donors and they were just fine and that made me think okay well if they’re fine so I’ll be fine.’ (Female Novice donor, aged 56)

Pay it back (women about parents): ‘My mother was very ill for a year and had about 6 or 7 blood donations. …It was just about giving back’. ‘I just felt a very strong need to give back what she’d been given by other people’. (Female Novice donor, aged 56) and ‘I had my first one [donation], when I was 19, and I did because my father actually needed it. He was passing away so he was after [blood].’ (Female Experienced donor, aged 39)

Pay it forward (women about children): ‘…you know going down [to the donor centre] I’d feel a little bit pleased; a little bit scared; a little bit irritated. I’d feel all these emotions even a little sad because you’d know that you’re not giving blood for it not to go to help somebody and you’d think of whether it be your grandparent or child.’ (Male novice donor, aged 42).
Recognition/reinforcement

Recognition is the public communication of a person or organization’s respect for an act or attitude that raises the status of the recipient (Belk 1995). Recognition by others is therefore an important reinforcement on behavior which indicates peer approval and thus motivates people to help others (Fisher and Ackman 1998). When looking at charitable behavior, recognition provides social reinforcement with other people’s perceptions providing confirmation of a person’s moral identity (Winterich et al 2013). This confirmation is a form of reflected appraisal whereby other people view the donor in the same way they view themselves (Winterich et al 2013). In this sample, younger donors mention desiring recognition in the form of a sticker, a sticky plaster on their arm or virtually via Facebook (e.g. a button or badge). The intention of the recognition was to let others know that they had donated, this was particularly expressed by lapsed donors: ‘Having that little bandage on your arm ……people see it…people say what happened to your arm? Oh I just gave blood’. (Female lapsed donor aged 41) and ‘I think people do want the recognition…certainly in the main they want some sort of….I think it adds to the value of the experience’ (Male lapsed donor, aged 61). In comparison, older donors indicated that public recognition would be a deterrent and that they viewed donation as a very private act: ‘The most important thing is I do this because I want to… I don’t look for kudos when I give blood. I just go in I give blood and you just walk out and you think thank Christ it’s not me that needs it. That’s the way I look at it. It’s a question of honour.’ (Male Experienced donor, aged 65).

Discussion

This study has identified that the influence of other people generates both positive and negative emotional experiences through social norms and personal connection. In turn this emotional experience (both anticipated and experienced) drives social support (particularly emotional support) and the need for other people to recognize the donation. These results can inform services marketing strategies for increasing blood donation. It would appear that normalization of the process and the act of donation could go some way to reducing negative emotions and supporting positive emotions, and allow people to capitalize on the potential support available from others around them (family and friends) who may already be donors. This may be an opportunity for the Blood Service to carry out some research testing and learning messaging aimed at broadening the discussion and ‘normality’ of Blood Donation within the community. Discussions that focus on the need for donors may indirectly be creating a social norm that most people do not donate which in turn makes it less normalized in the community thus presenting a more awkward barrier for potential new donors. During the donation experience, the Blood Service could encourage donors to check-in on Facebook and to mention they have donated afterwards on Twitter or on Facebook. This then creates a feedback loop that influences social norms, provides social support through demystifying the process or identifying themselves as a source of knowledge. This study has addressed the lack of evidence in service research that identifies how other people influence customers in a people-processing service where aspects of the body is the basis of exchange. Further research is needed to identify the specific contexts and service strategies that can be used whereby other people are an integral resource for generating loyalty to the Blood Service.

REFERENCES


*****

138. IMPROVING CUSTOMER WELL-BEINGS THROUGH SOCIAL SUPPORT IN ONLINE HEALTH COMMUNITIES: EVIDENCE FROM CHINA

Tang Yao, Beihang University, Beijing, P. R. China
Qiuying Zheng, Beijing University of Chinese Medicine, Beijing, P. R. China
Xiucheng Fan, Fudan University, P. R. China

INTRODUCTION

Patients of chronic infectious diseases, like hepatitis B, AIDS, and tuberculosis, suffer from not only
physical pains but also social exclusion. Their quality of life depends on better medical treatments and more importantly on social support as well. Given the insufficient supply of medical resources, the social support for patients in developing countries rely more on non-medical institutions. Thanks for the advancement and internet technology, patients with similar disease are easily connected with each other and able to help each other. This research aims to explore the dynamics of Online Health Communities and examine the impact of social support on patients’ well-beings.

Patients who suffered from social exclusion may have negative feelings and behavior; however, it is one of the basic human needs to maintain a stable and good relationship with others, since Chinese culture emphasizes interdependence more than western culture. Chinese culture focuses more on how the individual work with people and how to behave, and present a daily physical and mental dependence on each other. That is why Chinese people place more emphasis on the need for emotion. It is because the Chinese people care very much about how others think of and how to accept themselves, so if the individual is isolated by the relatives and friends due to disease, then the individual’s life will be of less meaning.

This papers aims to investigate what patients gain by interacting with one another in online healthcare communities and how these interactions affect their quality of life. Building on previous work in social support theory and quality of life practices, the authors identify three kinds of support (emotional support, informational support, and companionship) that underlie online social support in health care. Subsequently, the authors revealed eleven subcategories of online social support practices and linked these to patients’ quality of life. Theoretically, the authors constructed a conceptual model of the relationship between online social support and patients’ quality of life.

THEORETICAL FRAMEWORK

Our research definitely focuses on the issue about customers’ well-being and how to improve their quality of life, which has become one of the proprieties in the emerging domain of transformative service (Ostrom et al. 2010). For the next decade, Transformative Service Research needs pay more attention to well-being as the outcomes of service and delves into social questions about the way to enhance well-being, such as access to social networks and support, social justice, happiness, and so on (Ostrom et al. 2010). Specially, “TSR seeks to better the quality of life of present and future generations of consumers and citizens through services” (Anderson 2010, p. 6).

Social Support in Health Care Service

The influence of social relations on well-being has long been a subject of study across disciplines (Bambina, 2007). In health care sector, social support can reduce patients’ depression, anxiety and negative thoughts and further influence patient well-being and life satisfaction (Anderson and Agarwal 2011). The major body of sociology research categorizes social support from functional perspective into four forms, i.e., emotional support, informational support, companionship, and instrumental assistance (Berkman et al. 2000). Emotional support is transmitted through sharing happiness or sadness, or expressing the caring and concerns. Informational support transmits information, including advices and referrals. Companionship can be categorized as groupings, chatting, and other social activities. Finally, instrumental or practical support refers to the assistantship in life-related resources.

Quality of Life as an Indicator of Customer Well-Being in Health Care Service

Quality of life, defined as a sense of overall well-being (Aaronson et al. 1996), was selected as the indicator to judge the outcome of online social support. General quality of life is determined by individuals’ evaluation of their life (Ferrans 1990) and the positive or negative attributes that characterize their life condition (Ferrell, Wisdom, and Wenzl 1989). Given the health care context of the present study, we focuses on health related quality of life instead of the general one.

METHODS

Hepatitis B is selected as the research setting due to: (1) Hepatitis B is a common pandemic infectious disease in China (Li and Zhuang 2012); (2) Anti-Hepatitis B Forum is one of the most popular and most active online forums.

Construct operationalization and measures

Three steps were undertaken to collect data and test the relationship between online social support behavior and patients’ quality life. Firstly, we captured posts published by online health care community members in the relevant sectors of Anti-Hepatitis B Forum as samples. Finally, 1,425 themes were obtained as valid samples. Secondly, depth interviews through instant messaging (e.g., MSN, Skype, or Wechat) were employed to find out what kinds of online social support HBV patients actually accept and whether the social
support could improve patients’ quality of life, including both physical and psychological aspects. 15 interviewers participated in this step. Thirdly, we collect data containing 387 samples from the online healthcare community to explore the relationship between online social support and patients’ quality of life.

RESULTS

Types of Online Social Support
Our first task was to answer whether online social support exists for patients and what kinds of online social support they can get from patients online communities. According to content analysis on posts collected from online healthcare community, three categories and eleven subcategories of online social support were identified, i.e. emotional support is divided into: (1) understanding/empathy, (2) encouragement, (3) affirmation/validation, (4) sympathy, (5) caring/concern, (6) blessings /congratulations; informational support is divided into: (1) advice, (2) referral, (3) teaching; and companionship is divided into: (1) chatting, (2) humor/teasing.

Online Social Support and Quality of Life
Our second task was to further identify the online social support subcategory variables and their effects on patients’ quality of life. As shown in Figure I, a brief structure of interactions between online social support and quality of life was concluded by the results of depth interviews.

![Image: Diagram of Online Social Support and Quality of Life](image)

**Figure I.** Structure of Interactions between OSS and QOL

Empirical Evidence of Online Social Support Influence on Quality of Life
Our third task was to quantitatively analyze the relationship between online social support categorical variables and patients’ quality of life. Table 1 provides the results of the measurement model analysis for the confirmatory study. Table 2 exhibits the SEM results relevant to both proposed model and alternative model, and finally accepted structure model are shown as Figure 2.

| Research Construct     | M  | SD  | Parameter Estimates CFA | Construct Reliability | Average Extracted Variance | 1st  | 2nd  | 3rd  | 4th  | 5th  | 6th  | 7th  | 8th  | 9th  | 10th | 11th |
|------------------------|----|-----|-------------------------|-----------------------|---------------------------|------|------|------|------|------|------|------|------|------|------|
| 1. Emotional Support   | 5.31 | 0.85 | 0.77 | 0.84 | 0.94 | 0.65 | -   | 0.22 | 0.22 | 0.25 | 0.26 | 0.40 | 0.40 |
| 2. Informational Support | 4.97 | 1.07 | 0.84 | 0.82 | 0.95 | 0.78 | -   | -   | 0.74 | 0.31 | 0.19 | 0.19 | 0.19 |
| 3. Caring/concern      | 5.08 | 0.85 | 0.87 | 0.86 | 0.98 | 0.72 | -   | -   | 0.82 | 0.52 | 0.45 | 0.45 | 0.45 |
| 4. Physical QOL        | 5.23 | 1.29 | 0.82 | 0.82 | 0.97 | 0.78 | -   | -   | 0.38 | 0.18 | 0.18 | 0.18 | 0.18 |
| 5. Psychological QOL   | 5.53 | 1.04 | 0.87 | 0.88 | 0.92 | 0.74 | -   | -   | 0.31 | 0.21 | 0.21 | 0.21 | 0.21 |
| 6. Existential QOL     | 5.03 | 0.85 | 0.82 | 0.89 | 0.93 | 0.70 | -   | -   | 0.70 | 0.70 | 0.70 | 0.70 | 0.70 |

**Table 1.** Descriptive Statistics, Squared Correlations, and Measurement Model Results

| Research Construct     | M  | SD  | Parameter Estimates CFA | Construct Reliability | Average Extracted Variance | 1st  | 2nd  | 3rd  | 4th  | 5th  | 6th  | 7th  | 8th  | 9th  | 10th | 11th |
|------------------------|----|-----|-------------------------|-----------------------|---------------------------|------|------|------|------|------|------|------|------|------|------|
| 1. Emotional Support   | 5.31 | 0.85 | 0.77 | 0.84 | 0.94 | 0.65 | -   | 0.22 | 0.22 | 0.25 | 0.26 | 0.40 | 0.40 |
| 2. Informational Support | 4.97 | 1.07 | 0.84 | 0.82 | 0.95 | 0.78 | -   | -   | 0.74 | 0.31 | 0.19 | 0.19 | 0.19 |
| 3. Caring/concern      | 5.08 | 0.85 | 0.87 | 0.86 | 0.98 | 0.72 | -   | -   | 0.82 | 0.52 | 0.45 | 0.45 | 0.45 |
| 4. Physical QOL        | 5.23 | 1.29 | 0.82 | 0.82 | 0.97 | 0.78 | -   | -   | 0.38 | 0.18 | 0.18 | 0.18 | 0.18 |
| 5. Psychological QOL   | 5.53 | 1.04 | 0.87 | 0.88 | 0.92 | 0.74 | -   | -   | 0.31 | 0.21 | 0.21 | 0.21 | 0.21 |
| 6. Existential QOL     | 5.03 | 0.85 | 0.82 | 0.89 | 0.93 | 0.70 | -   | -   | 0.70 | 0.70 | 0.70 | 0.70 | 0.70 |

**Table 2.** Results of SEM Analysis

- **χ^2:** χ^2 test statistic
- **df:** Degrees of freedom
- **RMR:** Root Mean Square Residual
- **GFI:** Goodness of Fit Index
- **NFI:** Non-Normed Fit Index
- **IFI:** Incremental Fit Index
- **CFI:** Comparative Fit Index
- **RMSEA:** Root Mean Square Error of Approximation

1061.61 | 0.06 | 0.64 | 449 | 2.35 | 0.83 | 0.91 | 0.95 | 0.95 | 0.06
DISCUSSION AND FINDINGS

Our findings validate and more importantly extend Bambina’s (2007) work on depicting categories of online social support. We develop and validate a model to explain patients’ quality of life changes with respect to social support they receive in online health care communities. Patients’ participation in online communication and discussions enabled them to learn from other participants, and enjoy a partial prevention effect that reduced the possibility of their physical and psychological condition deteriorating. These findings can be used to encourage patients who are suffering from social exclusion in factual world to release their negative emotions and obtain renewed self-confidence to fight against diseases and return to a healthier state.

We showed that the more benefits a patient obtained from online health care community the higher the probability of his or her maintaining health.

Eleven broad themes of online social support were identified, comprising emotional support, informational support, and companionship namely: (1) understanding/empathy; (2) encouragement; (3) affirmation/validation; (4) sympathy; (5) caring/concern; (6) blessings/congratulations; (7) advice; (8) teaching; (9) referral; (10) chatting; (11) humor/teasing. These themes provide a basis for an online social support model.
support subdivision dimension measurement scale in the health care context. As such, our study extends beyond Bambina’s (2007) conceptual framework for considering social support in online customer health care communities.

To summarize, the results of the empirical study indicated that the informational support, emotional support and companionship affect patients’ quality of life in order of importance respectively. Web administrators should adjust and redesign if necessary the scopes and layouts of online health care communities in order to meet patients’ needs to seek assistance, reconstruct interpersonal intercourse, and improve personal health state physically and psychologically. Such conclusions are critical to impelling reform and perfection of Chinese health care system, and producing deep and even new knowledge in health care service research and ultimately to the advancement of service science.

**Managerial Implications**

The findings of this study make the interaction between online social support and patients’ quality of life clear. These patients meet online and exchange social support needed to reconstruct interpersonal relationship and placate negative emotions in a special kind of virtual community. As the online social support ultimately affect patient well-being (Coulson 2005; McMullan 2006; Bambina 2007), understanding how the support are formed and functioned is of critical importance to health care service providers. Undoubtedly, patients will be interested to learn which online social support is the more effective on enhancing health care quality. This means that patient receptions of online social support may increase probability of maintaining a good state. Indeed, according to our results, emotional support, informational support and companionship all play key roles in the improvement of quality of life perceptions, although the impact is different across various quality of life domains.

**REFERENCES**


The higher loyalty tiers achieved by greater spend provide customers with greater rewards and privileges. In a blood donation context, the challenges of donor retention and share of donor resources are paramount to operations. However, in the recommended voluntary, nonremunerated setting of blood collection (World Health Organization, 2009), financial incentives cannot be used to bind the donor to the organisation, or to maximise donation behavior. Thus, there is a heavy reliance placed on communication campaigns, urging donors to return, donate more, or where eligible, “upgrade” from whole blood (WB) to plasmapheresis (PLS) donation, a behavior that involves a greater cost to the individual in terms of time and potential discomfort (Bove, Bednall, Masser, & Buzza, 2011). Indeed, given the increasing demands for PLS, combined with the need to import the shortfall in national demand, the Australian Red Cross Blood Service (Blood Service) employs a plethora of communication campaigns to persuade eligible WB donors to convert. Recent examples have included ‘Golden Gift’, ‘Step Up’ (to plasma) and ‘Super Donor’, all of which suggest that plamapheresis is a superior donor behavior, an upgrade, not too dissimilar to the achievement of a higher loyalty tier.

Against this background, blood collection agencies (BCAs) such as the Blood Service need to respond to inventory needs that may vary by season or crisis (Caulfield, 2013). For example, WB inventory typically drops in the winter months as a direct consequence of increased illness of donors. Thus, although having dedicated panels of WB or PLS donors offers some predictability in supply, having donors that are willing and able to move between panels as a response to inventory needs would be very desirable. Herein lies the challenge: how to encourage donors to move between panels when communication campaigns have indicated that there is a hierarchy of donation behaviors and in turn, loyalty tiers with different rewards. Thus the aim of this study to understand how donors who are in this ‘top tier’ view this ‘flexible’ donation behavior. Using in-depth interviews augmented by a focus group, insights are gained as to some of the unintended consequences to which the current tiered-based PLS conversion persuasion practice may lead.

**THEORETICAL FRAMEWORK**

To understand how donors may react to impending perceived status level changes, we draw on status seeking (Emerson, 1962) and prospect theory (Kahneman & Tversky, 1979). Status seeking clarifies donors’ motivation to climb the tiered levels of donation type because they receive benefits such as recognition and self-esteem to which they had no access before the status elevation. Indeed, “individuals tend to prefer status-seeking activities which serve non-status purposes at the same time that they generate status, other things being equal” (Congleton, 1989, p.184). Namely, PLS donation demonstrates the donor’s higher level of investment and competence while simultaneously advancing the altruistic interests of the BCA. Further, although the ego-rewards obtained by status are highly valued by many recipients they are low cost to the giver (Emerson, 1962), which is consistent with the blood donation context.

Prospect theory also includes the individuals’ perceived value of behavior in decision making (Kahneman & Tversky, 1979). It proposes that when deciding, an individual rates each potential outcome in terms of the value or utility of the outcome and the likelihood of outcome. Results of making a decision are considered as either a gain or a loss, not in absolute terms, but in relation to a reference point (i.e., reference dependence). Deciding on whether to be flexible or not will be determined by the donor’s perceived gain or loss of making the requested donation type. For example, for plasma donors, the decision would be whether to make a WB donation and the reference point will be making a plasma donation. Both donation types would contribute to the BCA and for the plasma donor a range of potential gains are available through making a WB donation. Specifically it is a behaviour that donors have previously engaged in, and it is of shorter duration and less physically invasive (i.e., return fluid not required) than PLS donation.

However, in the context of hierarchical marketing strategies and conversion to PLS on the premise that it is a superior donation contribution (e.g., saves more lives), making a WB donation may be perceived as a loss in status. Critically, prospect theory proposes that people are loss averse and so losses are given more weight than gains. As such, for PLS donors, this loss in status may outweigh the gains associated with making a WB donation.

In a commercial exchange context, higher status tiers are usually associated with conspicuous relational benefits such as preferential treatment and access to exclusive services. Although PLS donation status indicators (e.g., priority treatment, dedicated, experienced nurses, and a segregated area within the centre for donation) have now been all but removed due to the operational inefficiencies that they created, we need to explore if organisational persuasion messaging regarding conversion still elevates PLS donation to a higher level on the hierarchical structure in the minds of existing PLS donors. If it does, it is important to determine what the perceived benefits of PLS are for the donor given the removal of donation status indicators.
METHOD
This exploratory research consisted of ten donors whose last five donations were plasma; the most recent within three months of recruitment. They were randomly sourced from the Blood Service database and were telephone interviewed using a semi–structured interview protocol. This sample was supplemented with a focus group comprising ten participants. The typical participant was female, had been donating for nine years and had made six plasma donations in the previous five years. As part of a larger schedule, interviews explored donor reactions to a request to move towards flexible donation, namely move between donation panels as per BCA needs. Interviews ranged from 20 to 54 minutes (average 32 minutes) and the duration of the focus group was one hour and 14 minutes. Interviews and focus group were recorded and transcribed verbatim for analysis.
Qualitative analysis software (NVivo version 10) was used for thematic analysis. Transcripts were read through carefully and initial codes identified. Two raters then coded one transcript against the initial framework; kappa value of .98 indicated excellent inter-rater reliability.

FINDINGS
Although the initial consensus was that PLS donors were willing to donate whatever the BCA required, probing uncovered a number of reasons which suggested resistance to this request. These included: confusion as to why the BCA would make such a request, and the perception that compliance would result in a status loss as donors ‘stepped down’ to an inferior donation. Further, PLS donation was seen to have been earned as only a few donors qualified. Donors perceived this superior donation behaviour as affording greater expressions of commitment with the BCA due to the higher level of investment it required, allowing greater opportunities for establishing donation routines and maintaining donors’ current lifestyle. These reasons are expanded upon below.

Consistent with current campaign messaging and participants’ experience of prior plasma donation requests, there was confusion as to why donors would be asked to change donation type: “Yeah, if they don't need – well, I don't know. I can't imagine why they wouldn't need the plasma” (Female #14, Interview). Such a request seemed contrary to the belief that plasma was in greater need and more useful than blood: “And there's, well, a perceived - from myself - higher need for that type of donation in the community, and what the blood service needs.” (Male #9, Interview) and “in actual fact it would help them a bit more if I donated plasma; simply because they can take more, they can turn it into a bunch of products ….” (Male #20, Interview). Some donors rationalised this request in terms of BCA severe inventory shortfalls. “If they were asking me to do it, there’s an extreme need for it.” (Female #27, Interview).

Donors spoke of a number of losses that would result from the requested change in donation. Some donors expressed negative emotions at the suggestion of donating WB again, including feeling “a little bit put out” (Male #2, Focus Group), “a little bit frustrated” (Female #3, Focus Group) or “disappointed” (Male #9, Interview). Donors explained these reactions in terms of WB seeming like a backwards step. For example, “…I’d feel yeah a little bit inadequate in comparison” (Female #3, Focus Group) and “You would be a little loss of … clearly you’re not that…” (Male #2, Focus Group). While this donor did not complete his sentence, he went on to describe WB donations as “we’re going back to this” (Male #2, Focus Group).

Plasma donation was perceived to be an opportunity made available to only experienced donors as it was an upgrade in skill level: “I was asked to; I was asked if I would consider it. They said because I’d been donating whole blood for long enough that if I was interested to”. (Female #4, Focus Group) and “If you have a lot of experience donating, then you will make that next step up to plasma donation.” (Male #20, Interview). The perception that donation types have a clear hierarchical succession with PLS close to the top appeared to come from communication with BCA staff: “They just asked me whether I would be interested and they explained the progression …” (Female #19, Interview).

There was also the perception that not every donor was qualified to do PLS, conferring specialist status to those that could: “Yeah I feel really proud I feel pretty special that I can do it I guess because a lot of people can’t and they want to.” (Female #4, Focus Group). PLS donation was seen as the domain of only a few donors which confirmed that it was special: “And then think there's only - again, there's a limited number of people who can do that as well. So I do have a perception that the plasma is probably more valuable.” (Male #10, Interview).

Notwithstanding that plasma donation was perceived as a more skilled activity for a limited number of qualifying WB donors, there was also the recognition that it demanded a greater level of investment from the
donor. For example, “… guess people who are more committed to being donors, are probably more likely to be donating plasma” (Female #5, Focus Group). Plasma donation not only required a greater level of contribution from donors but it allowed them to express their high level of commitment to the BCA: “Yes, certainly, definitely after being told the benefits of the plasma/platelets donations, and I guess the frequency as well, being able to donate more, you sort of feel that you are really becoming part of a whole process and sort of giving as much as you can.” (Male #7, Interview).

Some donors expressed resistance to changing from PLS in terms of the need to break the routine: “plus it’s easier… you just go there every fortnight and plug in.” (Male #1, Focus Group) and “I like plasma because I got into the routine of plasma; I was doing it every couple of weeks.” (Female #27, Interview). In addition to the potential frequency of PLS donation (fortnight) allowing behaviour to be more easily routinized than WB donation (12 weeks), PLS donation eligibility was seen to be more robust against donors’ lifestyle decisions, ensuring that they would be able to donate. For example, “I would probably prefer plasma because you don’t have the risk of going in and then not meeting the criteria on that occasion; not being able to come back for three months. That's what I had a couple of times with whole blood” (Female #27, Interview). Plasma donation was also perceived as allowing donors to recover quicker and continue their lifestyle “it is less exhausting or has the less fatiguing effect in the following days than the whole blood donation.” (Male #20, Interview).

**DISCUSSION**

This exploratory research provides some initial insights on how PLS donors react to the suggestion of flexible donation behavior in response to the BCA’s inventory needs. Akin to loyalty tiers where customers are recognized by their purchasing power, PLS donors also feel that they have high status because they see their status as earned, they are able to give more (larger volume) and more often (potentially every fortnight) than WB donors. Donors commented that to be a PLS donor one had to show competence as a WB donor, and not all those that were willing had the capability to donate PLS. Emerson (1962) labels this ‘the availability factor’. Thus, similar to the findings of Mathies and Gudergan (2012) where airline and hotel members threatened by a status downgrade exhibited strong brand preferences, so too did our PLS donors. As there are no economic rewards attached to the higher investment behavior of PLS donation and limited experience differences afforded by the BCA, it appears that PLS donors earn “ego rewards” (Emerson, 1962), the ability to feel special intrinsically, or extrinsically through increased respect and admiration from their peers and perhaps increased recognition from BCA staff. They also appear to earn lifestyle privileges with PLS donation perceived to impose less restrictions and consequences impacting their life.

For some donors, being asked for an alternate donation type was confusing and a possible loss of control experienced in the service encounter (Hui & Bateson, 1991). Further, such requests were associated with a loss of rewards and in turn, would likely negatively impact the psychological asset of their donor status. For example, Wagner et al. (2009) found that status demotion exerted a strong negative effect on perceived status benefits. Consistent with prospect theory, these potential losses would have a stronger effect than gains (Kahneman & Tversky, 1979), explaining the hesitation to comply with flexible donation behavior. Namely, the losses for a PLS donor (e.g., status and lifestyle privileges) are higher than the gains (e.g., cooperation, less demanding donation practice) to be achieved by assisting the BCA to meet its inventory needs.

Thus, these exploratory findings illustrate the potential problems of communicating a donor hierarchy tier based on donation type. Although successful in getting WB donors to convert to PLS, it is not conducive to donation behavior flexibility. If flexible donor panels are desired by the BCA perhaps a better strategy is to assess the donor’s potential suitability for flexible donation behavior early in their donation career, as our findings indicated a resistance to change once a routine is established. Experienced WB or PLS donors, as they enter the donation centre, would follow their habitual, automated script without consideration of more current goals or intentions (Wood & Neal, 2009). Flexible persuasive messaging should therefore start early in donor careers, and be framed to focus on the individual’s suitability to donation type and inventory requirements at that point in time. Terms or scripts which indicate a differential valuation of donors or donation types should be avoided. Indeed, a limitation of this research is that the awareness, perceptions and consequences of the donation hierarchy were not explored from the perspective of WB donors.

Future research should empirically track, using a longitudinal study, the donation frequency of those established PLS donors who comply to a request and make a WB donation as changes in status have been linked to changes in loyalty. For example, Wagner et al. (2009) reported that a status demotion reduced customer loyalty intentions to a level below those that existed at the point of being elevated to the preferred status. Further, demoted customer’s loyalty intentions were also found to be significantly lower than those
who had never experienced a status increase (Wagner et al., 2009). Future research should also explore the effects of occupying a premium status level on donor retention and donation frequency, as consumer research suggests that occupying a higher status is associated with higher loyalty (Lacey et al., 2007). If this effect held in the donation context, the higher loyalty behaviors of PLS donors as an outcome of the current status hierarchy would outweigh any advantages of donation flexibility. In summary, this exploratory research has highlighted the unintended consequences that charitable and NFP organisations face when communicating a hierarchy of donation behaviors.

REFERENCES


World Health Organization (2009), Global Consultation - 100% Voluntary Non-Remunerated Donation of Blood and Blood Components, Melbourne, pp. 49.

*****

209. SERVICE INNOVATION IN THE SANITATION SECTOR

Caroline Saul and Heiko Gebauer
Swiss Federal Institute of Aquatic Research (eawag), Switzerland

Purpose: Improved and more affordable sanitation services are one of the main millennium development goals expresses by the United Nation. But in reality around two billion people still face severe and unsafe sanitation conditions. Sanitation addresses a basic human need and is an essential transformative service, which could improve human well-being in various ways (e.g., health, safety, dignity). Sanitation services in low-income countries rely on decentralized systems such as simple pit latrines, movable toilets, or public and share toilets. Both public and private sanitation providers have difficulties in creating innovations, which
make such sanitation services more sustainable and affordable.

**Design/methodology/approach:** We use a qualitative research approach covering six case studies of sanitation services in low-income countries. The qualitative research uses an ethnographic method, which mixes data collection procedures such as interviews, observations, and participations in workshops. These primary data were supplemented with secondary data such as research reports, project documentations, and so on. All primary and secondary data are composed into single case studies. Case studies have been analyzed through within and cross-case analyses.

**Findings:** Our findings highlight the role of business models in the context of service innovations. Sanitation is remains technically challenging, but innovation efforts now concentrate on innovations in the actual business model. First, we could develop a classification of different business models for making sanitation services work. A typical illustration of such a business model would be a *sanitation system integrator*, which manages the whole sanitation chain from toilet usage, capturing, treatment, and resource recovery. An alternative business model would be a *sanitation franchising*. This approach seems to be attractive for managing shared toilet facilities or franchising toilet production and installation. Second, we could explore the key challenges in the evolvement of these different business models.

**Research limitations/implications (if applicable):** Qualitative research leads to some research limitations.

**Practical implications:** The article offers guidelines for sanitation businesses in low-income countries to modify their business models and to make sanitation services safer and more affordable.

**What is original/value of paper:** We offer insights into business model innovations in highly relevant sector for transformative services. We cover both a business model classification (outcome-based perspective on business model innovations) and a better understanding of how business models unfold over time (process-based perspective).

***

237. A VALUE CONCEPTUALIZATION

Mele C., Russo Spena T., Casbarra C., Tregua M.

University of Naples “Federico II”, Italy

**Purpose:** The paper aims to provide a conceptual framework to understand the value phenomenon in a more comprehensive and integrated view. We started from three research streams:
1. value as phenomenological experience (Helkkula et al., 2012) and context grounded (Vargo and Chandler, 2011).
2. transformative service research (Rosenbaum et al., 2011; Anderson et al., 2011, 2012), where the focus is on consumer’s wellbeing and on social, economic and cultural issues affecting customers’ lives through consumption activities.
3. value conceptualization in biology, ecology, environmental economy literatures (Dziegielewska et al., 2009; Mace et al., 2012).

This paper takes into account the multidimensionality nature of value to overcome the lack of a systemic view of value as well as the flood of different terms used to describe value.

**Methodology:** We analyzed two companies from different industries and with different approaches. The
analysis took place with an abductive approach to offer a value conceptualization (Dubois and Gadde, 2002). The work is based on a qualitative research method in which we combined the case study method (Yin, 2002) with a narrative approach (Greenhalgh et al., 2005).

**Findings:** We provide an interpretative framework offering a conceptualization of value based on four categories: “use value”, “option value”, “existence value” and “bequest value”. Each of these categories provides a focus on the multidimensional nature of value included both use (Humphreys and Grayson, 2008; Grönroos, 2008) and non use (Krutilla, 1967; Walsh et al., 1984) dimensions.

**Originality:** The paper discussed the application of a conceptual framework in understanding the value as a multidimensional concept explaining how different components configure benefits in a deeper meaning close to the wider idea of wellbeing. This framework provides a comprehensive typology of value considering economic, social, and cultural issues.

*****

247. EXAMINING PATIENT LOYALTY UNDER CAPITATION SYSTEMS: A SERVICE ENCOUNTER PERSPECTIVE

Fu-Ren Lin\(^1\), Pei-Shan Hsieh\(^2\)

\(^1\)Institute of Service Science, National TsingHua University, Taiwan
\(^2\)Institute of Technology Management, National TsingHua University, Taiwan

**INTRODUCTION**

Patient loyalty is particularly important under a capitation system, whereas the service provider (e.g., a hospital, a clinic, or a physician) receives a fixed “per capita” amount for each patient served (Gold et al. 1995). A service provider can take the part of the amount paid as profit if the patient uses few services, and has to absorb the excessive expenses if the patient consumes many services. In addition, patient loyalty is crucial within a capitation system because patients now have more freedom to choose among alternative providers. Therefore, creating the patient experience is an important variable in relation to creating value for the patient and, as previously indicated, is central to building loyalty. Consequently, we extend the traditional patient experiences only in the clinical interactions, but take a closer look at the patient’s experience with respect to service encounter to understand the drivers of loyalty. The major focus of the study is on the experiences—patient loyalty, which is an extremely important topic in health services and marketing research. Notably, we test a more comprehensive model of the several key antecedents and outcomes of patient loyalty by examining the cumulative patients’ experiences. This research also contributes conceptually to current research on antecedents and outcomes of patient loyalty. Furthermore, our study will help health care service providers because it assists hospitals in identifying which service encounters that need the most improvement and therefore need more resources allocated to them.

**THEORETICAL FRAMEWORK**

**Patient Loyalty**

Oliver (1999) defined loyalty as: “…a deeply held commitment to rebuy or repatronise a preferred product/service consistently in the future, thereby causing repetitive same brand-set purchasing, despite situational influences and marketing efforts having the potential to cause switching behavior”. In the health care setting, Roberge et al. (2001) defined patient loyalty as a “behavior, which is influenced by various facilitating factors including the commitment of the two parties, patient trust in the physician and the quality of the interpersonal relationship”. Moreover, in the current study and in accordance with customer experience literature which asserted that customer experience affects loyalty behaviors (Berry et al., 2002).
The role of patience experience
Experience reflects customers’ overall assessment of value (Maklan and Klaus, 2011) and relates to service perceptions through encounter with the service provider. The more positive experiences customers experienced, the higher the possibility that they tended to revisit and recommended to relatives and friends (Sheather and Roberts, 2003). In other words, positive experience affects a customer’s loyalty. In addition, the notion of service experience, and its impact on business, is only now receiving great attention (Klaus and Maklan, 2011). Creating superior customer experiences is now seen as a key objective for service organizations (Verhoef et al., 2009) in their efforts to build customer loyalty. Accordingly, we test the following hypothesis:

H1. In health care services, patient experience is positively associated with patient loyalty.

An encounter view of patient experience’s antecedents
Experience is the take-away impression formed by customer’s encounters with services, and a perception produced when humans consolidate sensory information. Service encounters can occur without any human interaction element, and not limit the encounter to the interpersonal interactions between the customer and the firm (Shostack, 1985). Turning attention to the health care literature, Zifko-Baliga and Krampf (1997) are pioneer the study of specific service encounter in the medical field. A number of studies have developed structure, process, and outcome three components to help researchers pinpoint what is important to patients and how they perceive the service encounter. For example, they found the encounter with doctors or other staff, and other dimensions as professional expertise, validation of patient beliefs, interactive communication, image, antithetical performance would affect patients’ service quality perception of hospitals. Most previous studies focus on the clinical encounter. However, patients in different health service encounters can influence the quality of healthcare delivery. This has led the World Health Organization (WHO) to acknowledge non-clinical health service delivery as being an important dimension of overall service delivery and quality of care. As a result, this research extends the work of these authors by examining experiences associated with evaluation of different service encounters, because the patient’s experience of a health care provider is a culmination of numerous encounters. We develop four constructs to be patient experience antecedents with logical view of encounter. These four constructs are service/information accessibility, hospital administration, interaction with professional and follow-up care. It is therefore proposed that:

H2. In health care services, service/information accessibility is positively associated with patient experience.
H3. In health care services, hospital administration is positively associated with patient experience.
H4. In health care services, interaction with professional is positively associated with patient experience.
H5. In health care services, follow-up care is positively associated with patient experience.

METHOD
The survey was administered to a total of 376 patients of different clinics in CTH (Cardinal Tien Hospital) in Taiwan. In accordance with the study protocol, an investigator approached adult patients when they were waiting appointments with their physicians and briefly described the study to the patients.

Construct operationalization and measures
We operationalize each investigated construct using a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree).

Patient loyalty: It was captured in terms of cognitive loyalty (3 items) (Zeithaml et al., 1996; Butcher et al., 2001), attitudinal loyalty (3 items) (MacStravic, 1991; White and Schneider, 2000) and behavioral loyalty (3 items) (Rowley et al., 2000).

Patient experience: 7 items described as the patient’s experience about the outcome of clinical service, or return to normal work and leisure activities (Zifko-Baliga and Krampf, 1997).

Information/service accessibility: 8 items about patient access people, premises, information and assessment about the service provider was measured by researchers, such as Lemke (2011); Payne et al. (2008); Ferguson and Paulin (2010).

Hospital administration: 10 items was borrowed from Zifko-Baliga and Krampf (1997), as the factors that can be controlled by the service provider and ensured a hospital operates efficiently, which measured by the
adequate parking spaces, cleanliness and quietness of hospital environment etc.  

*Interaction with professional:* There are 16 items was borrowed from Pettersen et al. (2004) and HCAHPS Survey (Darby et al., 2005).

*Follow-up care:* We developed 4 items for follow-up care, such as support groups, home care services, telephone follow-up (TFU) and tele-healthcare based on Mistiaen and Poot (2007) and National Cancer Institute (NCI).

## RESULTS

**Measurement Validation**

The analyzing tool is SPSS (Statistical Package for the Social Science) for Windows 14.0. We assessed the validity and reliability of the measures for constructs using confirmatory factor analysis (CFA). Following Anderson and Gerbing (1988), we first estimated the CFAs, which provided an acceptable fit to the data. We report the reliability estimates (Cronbach’s α, composite reliability, and average variance extracted [AVE]) for the constructs in Table 1. Factor loadings were significant (Anderson and Gerbing, 1988) and the estimates of the AVE were equal to or higher than .50 (Bagozzi and Yi 1988). These two sets of findings supported the convergent validity of the scales.

**Hypothesis Tests**

Path analysis was used to examine the relationship of each variable. Patient experience has a mediating effect on patient loyalty was supported, and the whole explanatory power was .821 ($R^2=.821; p<0.001$). In addition, patient experience has proved the predicting effect of different health service encounter. For hospital administration, and interaction with professional were positively significant to it ($\beta=.268; p<0.001$; $\beta=.628; p<0.001$). However, information/service accessibility and follow-up care were not positively significant to it ($\beta=.038; p>0.001$; $\beta=.002; p>0.001$).

### Table 1: Validation for the Independent Variables

<table>
<thead>
<tr>
<th>Construct</th>
<th>M</th>
<th>SD</th>
<th>CA</th>
<th>CR</th>
<th>AVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information accessibility</td>
<td>3.39</td>
<td>1.10</td>
<td>.87</td>
<td>.92</td>
<td>.79</td>
</tr>
<tr>
<td>2. Hospital administration</td>
<td>3.79</td>
<td>1.26</td>
<td>.96</td>
<td>.97</td>
<td>.88</td>
</tr>
<tr>
<td>3. Interaction with professional</td>
<td>3.76</td>
<td>1.28</td>
<td>.97</td>
<td>.98</td>
<td>.90</td>
</tr>
<tr>
<td>4. Follow-up care</td>
<td>2.97</td>
<td>1.15</td>
<td>.94</td>
<td>.96</td>
<td>.89</td>
</tr>
<tr>
<td>5. Patient experience</td>
<td>3.66</td>
<td>1.27</td>
<td>.97</td>
<td>.98</td>
<td>.90</td>
</tr>
<tr>
<td>6. Patient Loyalty</td>
<td>3.59</td>
<td>1.18</td>
<td>.95</td>
<td>.97</td>
<td>.88</td>
</tr>
</tbody>
</table>

Note. SD = standard deviation; CA = Cronbach’s α; CR = composite reliability; AVE = average variance extracted.

**DISCUSSION OF FINDINGS**

This study responds to recent trend for more research on capitation for patient loyalty and provides significant theoretical and practical implications. Drawing on past research, therefore, creating the patient experience is an important variable in relation to creating value for the patient and, as previously indicated, is central to building loyalty. Consequently, we extend the traditional patient experiences only in the clinical interactions, but take a closer look at the patient’s experience with respect to service encounter to understand the drivers of loyalty. Notably, we test a more comprehensive model of the several key antecedents and outcomes of patient loyalty by examining the cumulative patients’ experiences. There are no significant effects between first and last encounter and patient experience. However, hospital put more efforts in preventive healthcare because of capitation. So, the follow up care will become more and more important for patients. This research also contributes conceptually to current research on antecedents and outcomes of patient loyalty. Furthermore, our study will help health care service providers because it assists hospitals in identifying which service encounters that need the most improvement and therefore need more resources allocated to them.

**REFERENCES**


**Academy of Marketing Science, Vol.16 No.1, pp. 74-94.**


337. SERVICE-DOMINANT LOGIC IN HEALTH CARE: MAKING SENSE OF VALUE

Jon Engström and Lars Witell

Purpose: In this article, we aim to make a conceptual contribution to the understanding of healthcare in relation to SDL (Vargo and Lusch, 2004) and specifically its 10th foundational premise (SDL FP10; Vargo and Lusch, 2008).

Methodology: Using MacInnis (2011) typology for conceptual contributions in marketing, we relate SDL to the healthcare domain and make suggestions on the interpretations of SDL, building on conceptualizations of value and value creation in health care research.

Findings: The FP10 to SDL states: “Value is always uniquely and phenomenologically determined by the beneficiary”. In relation to the healthcare domain, we ask the following questions (1) who is the beneficiary, (2) what is value, (3) how can value be determined and (4) by whom? We suggest that while the primary beneficiary of healthcare is the patient, secondary beneficiaries of healthcare activities also include family, society and nations. Further, healthcare research strongly suggests that value in healthcare is a multi-dimensional construct with both objective and subjective components where notably clinical condition is objectively determined. Value in healthcare also relates to humanitarian values; life and health are goals in themselves and not only a means for achieving experience. In practice, and in line with medical ethics, this means that in healthcare, patients need help to co-determine value. A major challenge in healthcare is to assess value over time, and balancing short term costs with long term benefits.

Originality: Much of the service-oriented research on healthcare to date concerns chronic care and is focused on the immediate well being of the patient. This article nuances our view on value with the goal of stimulating more and diverse research that better relate to healthcare practice.

339. INTERDEPENDENT RELATIONSHIPS BETWEEN AND AMONG SERVICE PROVIDERS AND CUSTOMER COLLECTIVES

Julia Rötzmeier-Keuper¹, Nancy V. Wünderlich¹

¹ University of Paderborn, Germany

Purpose: Relationship models in literature often look at a single customer interacting with a service
provider, but tend to ignore the multi-dyadic relationships pertaining to not only one customer, but a “customer collective”. For example, in healthcare services customer collectives comprise a patient and his family and the relationships between and among providers and each member of the customer collective have the transformative power to affect the well-being of all involved parties.

**Approach**: Customer collectives comprise at least a core customer and another customer, who has the responsibility for, and is emotionally attached to the core customer. We aim to reflect these relationships from a principal-agent-perspective, and address the following research questions:

- How do the relationships between a service provider and each member of a customer collective affect each other?
- How do these interdependencies affect the well-being and satisfaction of both, customer collective and provider?

We conducted 58 semi-structured interviews in the context of the German pet services sector. The gained material sums up to about 1,800 minutes of audio material, which we analyze employing qualitative content analysis.

**Findings**: Relationships between pet (core customer), owner (other customer) and service provider are interdependent. The relationship intensity within the customer collective has an impact on the effectiveness and simplicity of the collaboration between service provider and customer collective in the service encounter. For example, a close relationship between pet and owner results in a complicated and ineffective collaboration with the provider. Thus, a successful collaboration influences the satisfaction with the service delivery and finally the well-being of the customer collective and the provider.

**Value**: Interdependent relationships within and between customer collectives and service providers are rarely considered in literature so far. The awareness of these interdependencies and their impact on customer well-being is especially valuable for emotional service offerings, such as healthcare.

****