(Araştırma)

FORMAL AND INFORMAL COMPONENTS OF THE SERVICE RELATIONSHIP IN HEALTH CARE[1]

Berna Tarı Kasnakoğlu [2] [4]

Yunus Kalender [3]

ABSTRACT

In this study, the term "relationship" is decomposed into formal and informal components, which better reflects the nature of service interactions. This paper intends to compare if either/both of these components are utilized (more) during interactions. Survey data is collected from 193 respondents. Both service partners are included in the analyses, with the recognition that co-creation is possible only through the active participation of both partners involved. Results indicate that both patients and physicians utilize formal relationship behavior more, but they both increase the level of informality when the other service partner behaves positively. Patients and physicians can use these results to shape their interactive behavior so that mutually satisfactory outcomes are obtained.

Keywords: Co-creation; formal relationship; informal relationship; service relationship; healthcare.

1 This research is funded by the Scientific and Technological Research Council of Turkey (TUBITAK Project # 112K464).

2 Doç. Dr. Berna Tarı Kasnakoğlu, TOBB Ekonomi ve Teknoloji Üniversitesi, İktisadi ve İdari Bilimler Fakültesi, İşletme Bölümü, btari@etu.edu.tr, ORCID ID: 0000-0002-8296-4107

3 Yunus Kalender, TOBB Ekonomi ve Teknoloji Üniversitesi, İktisadi ve İdari Bilimler Fakültesi, İşletme Bölümü, ykalender@etu.edu.tr, ORCID ID: 0000-0001-5963-9771

4 İletişim Yazarı / Corresponding Author btari@etu.edu.tr,

Geliş Tarihi / Received: 16.05.2019, Kabul Tarihi / Accepted: 19.09.2019

SAĞLIK HİZMETLERİNDE HİZMET İLİŞKİSİNİN FORMEL VE ENFORMEL BİLEŞENLERİ

ÖZ

Bu çalışmada, "ilişki" kavramı, hizmet etkileşimlerinin daha iyi anlaşılmasını sağlamak üzere, formel ve enformel bileşenlerine ayrılmıştır. Amaç, bu bileşenlerden herhangi birinin veya ikisinin (daha fazla) kullanılıp kullanılmadığı konusunda karşılaştırma yapabilmektir. 193 katılımcıdan anket verisi toplanmıştır. Ortak değer yaratımının her iki partnerin de aktif katılımıyla mümkün olduğu yaklaşımıyla, çalışmaya hizmet ilişkisindeki her iki taraf da dâhil edilmiştir. Bulgulara göre hem hastalar hem hekimler daha fazla formel ilişki davranışında bulunmaktadır; ancak ister hasta, ister hekim olsun, karşı partner daha olumlu bir davranış içerisinde oldukça daha enformel davranmaktadır. Hekimler ve hastalar bu çalışmanın bulgularından faydalanarak karşılıklı tatmin eden bir hizmet çıktısı için etkileşim davranışlarını şekillendirebileceği düşünülmektedir.

Anahtar Kelimeler: Ortak değer yaratma; formel ilişki; enformel ilişki; hizmet ilişkisi; sağlık sektörü.

1. Introduction

Previous studies on relationship marketing fundamentally assume that any relationship is good, and it would improve the consumer's satisfaction, positive affect, and loyalty. A lot of studies focus on how to build a marketing relationship, without in fact understanding what constitutes that relationship (e.g., talking, having further conversation after the service transaction is over, etc.) or whether all components in the relationship accrue for a true, positive relationship (e.g. body language, content of the conversation, etc.).

On the other hand, several scholars have found that some factors might lead to more negative feelings in the case of a service failure. Except for a few examples, studies mainly focus on the positive aspects of having a relationship, but there is no clue as to which particular behavior is actually better and why.

Lack of a clear explanation for what constitutes a relationship and how it affects the outcomes partly stems from an absence of differentiation between the formal (or usual) and the informal (or voluntary) components of a service relationship. To our knowledge, only Wan et al. (2011) distinguished between business relationships, exemplifying a formal interaction, and friendship, exemplifying an informal relationship. Additionally, almost all studies on this topic conceptualize a relationship as evolving through time, neglecting the real-life service situations in which a customer may encounter a service provider just once.

This paper intends to relax these assumptions, differentiate between the formal and the informal components of a service relationship, and compare if either or both of these components are utilized (more)in the specific context chosen at a single service encounter. Another contribution of this study is related to including both service partners with the recognition that co-creation (and mutually satisfying outcomes) is possible only through the active participation of both partners (Vargo and Lusch, 2008; Grönroos, 2011). Another aim in this regard is to understand different clusters of service partners who might be more or less willing to utilize different components of a relationship.

This study is exploratory and the aim is to understand the nature of different types of relationships in a single service construct. In parallel to this purpose, we needed to investigate whether the behavior of the other partners (the patient or the doctor) might affect how (formal or informal) one behaves, and whether this would lead to better service outcomes.The overall model is represented below.

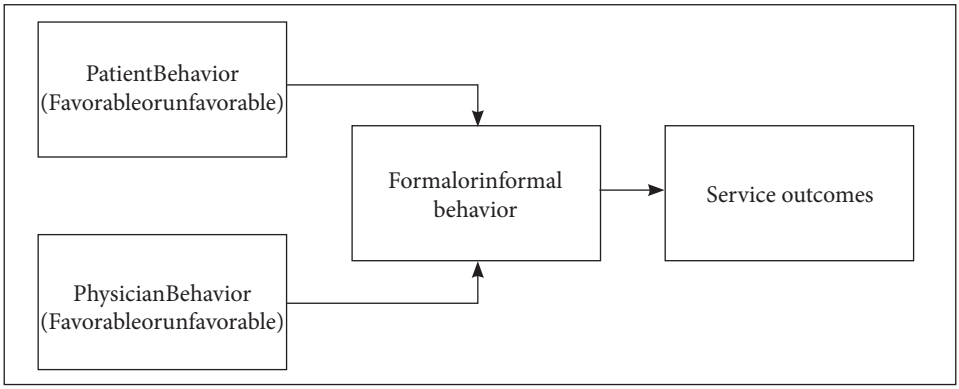

Figure 1. Research model

We do have some expectations; however, they are generally due to our motivation to understand rather than predict specific kinds of behavior. Overall*, our general hypothesis or expectation is that favorable behavior of the other partner leads to more informal behavior, which would make the conversation smoother between the patient and the doctor, leading to better service outcomes.*

2. Literature Review: Relationship in Service Encounters

The relationship component of marketing was studied under different names including interpersonal relationship (Chao et al., 2007), "true" interpersonal relationship (Wan et al., 2012), interpersonal service quality (Lee and Yang, 2013), interpersonal attraction and liking (Abosag and Naudé, 2014), non-utilitarian relationship (Elsharnouby and Parsons, 2010), emotional commitment (Berghäll, 2003), personal commitment (Jones et al., 2008), affective commitment (Kemp et al., 2014), affective trust (Sekhon et al., 2013), "boundary open transaction between provider and customer that transcends commercial interaction" (Arnould and Price, 1993: 41), communal relationships (Wan, Hui and Wyer, Jr., 2011), intimacy (Beetles and Harris, 2010), customer-staff affection (Yim et al., 2008), non-task conversation (Garzaniti et al., 2011), or friendship (Price and Arnould, 1999; Lin and Hsieh, 2011; Arnold et al., 2011). Some factors in the relationship might lead to negative outcomes (Wan et al., 2011; Holloway et al., 2009). A few other researchers have found adverse effects of having a personal relationship, such as Moorman et al. (1992), who have noticed that familiarity promotes boredom. Williamson (1996) has discerned that high levels of commitment can lead to opportunism in a relationship. Lastly, Ho (2012) has found that long-lasting friendship is beneficial only when the service transaction is unfavorable.

Therefore, customer involvement has been studied in different models since the 1980s (e.g. Berry, 1983), but the idea that "the customer is a co-creator of value" (Vargo and Lusch, 2008; Grönroos, 2011) has widely been accepted

as the new logic of service relationships only recently, where, in effect, every marketing transaction is perceived as a service. The dyadic relationship between the customer and the service provider can be maintained and shaped in various ways, and the high participation of both partners are likely to yield positive outcomes (Grönroos,2011; Crosby et al., 1990; Tari Kasnakoglu, 2016). Therefore, the term relationship becomes more than an everyday expression with this new understanding, reflecting the actual interface between service partners in a commercial setting.

A majority of recent studies (especially the ones that have adopted the co-creation philosophy) have chosen to concentrate on the mutually constructed relationships that last for more than a single transaction (e.g. Di Mascio, 2010). Some of them directly use the duration of the relationship or frequency of service contact as important determinants (e.g. Ward and Dagger, 2007). By corroborating the "relationship formation" argument, they explore how different factors play different roles in the creation and development of such a friendship, in the form of cooperative intentions (Crosby et al., 1990) or interdependency (Ma and Dubé, 2011). The conceptual framework for value co-creation requires several encounter processes, which would then influence the relationship experience. Price and Arnould (1999) insist that a commercial friendship is characterized mostly by its formation process, which includes many aspects such as intimacy, instrumentality, and social bonding.

Scholars who concentrate on single service encounters, however, have mostly investigated the effects of frontline employee behavior. Hennig-Thurau et al. (2006) have found that employee smiling does not affect customer emotions. Folkes and Patrick (2003) have observed a positive effect on service encounters. But more research is needed to understand the face-to-face, interactive nature of one-time service relationships. In many of the service situations, there may not be an opportunity to develop a "true" friendship over time. Therefore, it is as important to understand a short-term relationship that grows in a single service situation as it is to understand long-term relationships that have already progressed to a great extent.

As a result, there is a need to investigate how face-to-face interaction is accentuated through relationship behavior in one-time service contexts. The recent rise of the co-creation discussion may provide a platform to have more in-depth studies on the issue of interactive relationship, and this study is an attempt to see how formal and/or informal interaction behavior is employed by two service partners in a single service encounter.

2.1. The Context of Health Care

Health care is specifically important in this discussion for a variety of reasons. First of all, it is one of the most common services that millions of consumers

demand on a regular basis; and in such a service context, where no tangible object is exchanged, the encounter itself may become the only determinant of service quality and satisfaction (Jayanti and Jackson, 1991). Secondly, consumer participation in health care has become a topic of intense discussion because it is seen as part of a process of professional patient-consumer participation in health care decisions (Jordan and Court, 2010). Moreover, the patient-physician relationship is asymmetric (Friedman and Churchill, Jr., 1987), with the physician dominating the interaction because of his/her expertise and technical knowledge, making this service interaction more interesting compared to regular interactions in a fast-food restaurant or a shoe store.

The health care industry has always been in the process of change throughout the world. The ideology that the doctor is the sole producer (Stevenson, 1978) has also been modified towards the view that the doctor is not only the medical expert, but she or he is also an emotionally intelligent person and a good facilitator of communication (Lee and Lin, 2010). The relationship between the doctor and the patient is now perceived to be as important as the institutional aspects of the health care transformation directly affecting patient satisfaction almost regardless of the medical outcome (He and Qian, 2016).

Looking at the health care sector statistics, global health care expenditure is expected to increase at an annual rate of 5.4% up to $10,059 trillion (Deloitte, 2019). The market is expected to grow also in terms of the technologies, which may increase expenditures even more. Within this huge sector, the patient is turning into a consumer, too; hence the term "patient-consumers," with increased agency, increased level of knowledge gathered from the online sources and more accessible due to better financial resources and improved living conditions. It would be an over-ignorance not to study this sector from the relationship perspective based upon the quick glimpse made above.

In Turkey, based on official statistics, the number of physicians in 2017 was almost 150 thousand, with 539 patients per one doctor and 4,793 visits by the patient to one doctor (TUIK, 2019). This statistic covers all physicians working in public and private sectors, and hence reflects a very important issue: It may be very difficult to establish a proper relationship even if the co-creative attempts by patients and physicians were present, because of high turnover rates and a large crowd of patients waiting outside the doctor's office. This situation makes our topic even more important in the context of Turkey.

3. Methodology

This study is a scenario-based experimental study in which participants are asked to read a scenario describing a physician/patient acting favorably or unfavorably. After reading the scenario, the participant answers questions based on how s/he thinks and feels about the set-up presented in the scenario.

3.1. Scenario-Based Experimental Study Design

We needed to manipulate whether the other partner in the relationship (the patient or the doctor) behaves in a favorable, co-creative manner or not. Therefore, the direct encounter between the consumer and the provider was manipulated through a scenario. One of the scenarios described a caring and friendly physician with high professional ethics who illustrated participating activities, while the negative scenario represented a physician who chooses not to provide service based on a high-quality relationship. Therefore, the positive/negative scenario described a physician illustrating favorable/unfavorable behavior towards the patient. The same strategy was followed for the physician side, where a positive patient represented the favorable scenario, and an uncooperative patient represented the unfavorable scenario.

The questionnaire starts with this scenario introducing a physician/patient who behaves either positively or negatively. A positive physician scenario exemplifies a doctor who welcomes the patient, smiles, and tries to make the patient feel comfortable. S/he listens to the patient carefully concentrates on the patient and provides necessary details when necessary. A positive patient scenario describes a patient who is clear about his/her mind, coming to the doctor's office prepared, and who can contribute to the consultation by providing sufficient explanations. Negative scenarios were almost the exact opposite of the positive scenarios. Pilot tests indicated that the physician in the positive scenario was found to be significantly more favorable, with a mean difference of 3,686 (p-value<.000). Similarly, the patient in the positive scenario was perceived as more favorable, with a mean difference of 2.602 (p-value<.000).

3.2. Measurements

The participant, after reading the scenario, answers whether the patient/physician in the scenario is acting favorably or not (manipulation check), and continues to answer whether s/he would engage in any of the behaviors (formal or informal) listed, and lastly answers questions as regards to their perceptions of the service outcomes. The survey questions were developed for the purposes of this study. Two other measures involved the formal and informal relationship as perceived by each service partner. For patients, formal behavior was represented by five activities (α=.614), and the informal relationship was measured by asking eight questions as regards the personal and service-specific relationship from the patient's perspective (α=.925). Formal relationship as perceived by the physician composed of four items (α=.779) and the informal relationship as perceived by the physician was tested by using seven items (α=.838). All questions were asked using 6-point scales. Multicollinearity check was conducted among the three variables (formal relationship, informal relationship, the outcomes), where patient-related VIF statistics were found to be 3.348, 1.966, and 1.939, all below 10, indicating no such potential for collinearity (Wetherill, 1986). VIF statistics for the same variables on the physician side yielded scores of 1.865, 1.498, and 1.807.

The outcome variable consisted of five questions asking (1)the level of satisfaction from the relationship, (2)whether the patient finds the service effective, (3)whether s/he would be willing to forgive the physician in case of a problem, (4)whether s/he would choose the same physician for the next time and (5)whether s/he would engage in positive word of mouth. These items were internally consistent (α=.899). A composite "outcome" variable was created by taking the average of these five items. Outcomes for the physician consists of three items asking (1)if the physician is satisfied in regards to the person, (2)whether s/he is satisfied in regards to the relationship, and (3)whether s/he finds the specific service provision effective. Internal consistency was found to be high (α=.914).

3.3. Data Collection

The data was collected using 193 face-to-face encounters with people from different backgrounds on a convenient basis, in Ankara and Izmir, two different cities in Turkey. The sample with the negative physician scenario consisted of 25 females and 15 males, with an average age of 27.27. The sample with a positive scenario consisted of 24 males and 20 females, with an average age of 27.77. The two samples were comparable in terms of demographics. Participants were randomly assigned to one of two conditions. Data from physicians were collected at the same time with the patients. The negative patient scenario consisted of 21 females and 39 males, with an average age of 45.60. The positive scenario consisted of 15 females and 34 males, with an average age of 46.98. Mean comparison for independent samples yielded insignificant p-values, so it is safe to conclude that samples can be usedsecurely.

4. Results

Independent samples t-tests were conducted between patients and physicians and between two conditions for each service partner (Table 1 and Table 2).

Table 1. Mean Differences (Independent Sample t-tests) (Patient / Physician)

	Bad Scenario	Good Scenario	Difference
Formal	2.70 / 4.41	3.91 / 5.12	1.22** / 0.71**
Informal	1.59 / 3.37	3.23 / 4.23	1.64** / 0.86**
Outcome	1.77 / 2.87	3.61 / 5.05	1.83** / 2.18**

** Difference is significant at <.000

Table 2. Mean Differences (Independent Sample t-tests)

	Bad Scenario			Good Scenario		
	Formal	**Informal**	**Outcome**	**Formal**	**Informal**	**Outcome**
Physician	4.39	3.33	2.82	5.12	4.23	5.05
Patient	2.74	1.65	1.83	3.92	3.23	3.60
Difference	1.64**	1.68**	0.99**	1.20**	0.99**	1.45**

** Difference is significant at <.000

All results are signs indicating that one partner's behavior towards the other partner actually creates a difference in the level of formal and informal relationships, as well as positive outcomes. A regression analysis with outcomes as the dependent variable and the other partner's behavior (dummy variable indicating it is either favorable or unfavorable) as the independent variable shows that the partner's behavior directly affects outcomes (All p-values<.000).

Table 1 shows that the level of formal relationship behavior is always greater than the level of informal behavior. Both patients and physicians engage in more formal and informal behavior under the positive condition (when the other partner behaves favorably), and positive outcomes are apparently greater for both the patient and the physician. Physicians always engage in more formal and informal relationship behavior, and they are always more content with the results of this relationship; however, patients increase the level of formal and informal behavior under the good scenario more than physicians.

Therefore, our overall expectation is only partially satisfied based on the results summarized above. The level of informal behavior increases in the case of favorable behavior for both patients and physicians (Table 1 and the regression analysis), but the positive outcomes occur more significantly with informal behavior only under the good scenario. (Table 2).In other words, when the other partner is not behaving in a co-creative manner, only formal behavior leads to better outcomes.

Further analysis is conducted to see if service partners differ in terms of key demographic characteristics (age and gender), their approach towards formal and informal behavior, and perceived outcomes.

Table 3. Favorable Physician

	Cluster 1 (Female)	**Cluster 2 (Male)**
Size	**59.1%**	**40.9%**
Gender	0 (100%)	1 (100%)
Informal	3.09	3.44
Age	27.54	26.33
Outcome	3.65	3.54
Formal	3.92	3.92

The first cluster is composed of females who are only slightly above than males in the other cluster in terms of positive outcomes. They engage in less informal behavior (3.09 over 5, compared to 3.44) and become more content with outcomes when the physician's behavior is favorable (3.65 compared to 3.54).

Table 4. Unfavorable Physician

	Cluster 1 Female	Cluster 2 Male	Cluster 3 (Both genders)
Size	**55.3%**	**28.9%**	**15.8%**
Outcome	1.56	1.28	3.48
Informal	1.39	1.23	3.03
Gender	0 (100%)	1 (100%)	1 (58.3%)
Formal	2.62	2.42	3.62
Age	26.62	25.91	34.42

When the physician does not behave in a favorable manner, a majority of female and male patients become easily discouraged making them engage in less relationship-building behavior. One cluster of older patients, however, engage in more formal/informal behavior. They seem to be content with outcomes; in fact, they are more content than patients in the favorable condition (3.48 compared to 3.09 and 3.44).

Table 5. Favorable Patient

	Cluster 1
Size	**100%**
Gender	1 (66.7%)
Formal	5.04
Informal	3.62
Outcome	5.00
Age	46.00

When the patient behaves favorably, a major part of male physicians is very much content with outcomes, and they extensively engage in formal behavior. The level of informal behavior is lower for these physicians. There is only one cluster, indicating that physicians' behavior stays quite consistent when the patient is positive.

Table 6. Unfavorable Patient

	Cluster 1	Cluster 2	Cluster 3
Size	**55.0%**	**28.3%**	**16.7%**
Informal	3.08	2.72	5.46
Gender	1 (100%)	0 (100%)	1 (60%)
Outcome	2.62	2.27	4.73
Formal	4.22	4.06	5.65
Age	49.94	41.94	50.90

When the patient is unfavorable, however, a majority of physicians, who are male and comparatively older, become very unhappy about outcomes (2.27), however, their formal behavior does not decline significantly (4.06). Their informal behavior also stays at a medium level (2.72). Female physicians, however, respond more negatively to an unfavorable patient(2.62), and they engage in even less relationship-building behavior (4.06 formal, 2.72 informal behavior). The most important characteristic of the third cluster comprised of both males (60%) and females (40%) is that they engage in very high levels of informal behavior (5.46). This last cluster responds quite positively to an unfavorable patient by engaging in high levels of formal and informal behavior, and they become much happier about the results at the end (4.73).

5. Discussion and Implications

The results show that both patients and physicians engage in formal behavior more than informal behavior under both conditions. However, the increase in formal behavior is not as high as the increase in informal behavior when the service partner is in favorable conduct. In other words, although formal behavior seems to shape the service related to a great extent, the reciprocal positive behavior of the service partner leads to an increase in informal behavior. In addition, for physicians, the increase in formal and informal relationship behavior is not as high as the patients', indicating that physicians engage in a series of behavior which does not change much but can elevate to a slightly higher and more informal level if the patient is positive. A certain "role" is expected from and performed by physicians, and this role may be ritualistic in the form of a service script (Zeithaml et al., 1993; Solomon et al., 1985). In between the dual goals of predictability and personalization (Surprenant and Solomon, 1987; see Shen and Ball (2009) for adverse effects of personalization), physicians in this study apparently have chosen to be predictable. It is likely that physicians may still want to give details about the medical procedures, although they may not want to be any closer to the patient, even though the patient behaves favorably. Although physicians play the role of physicians hundreds of times, patients play the patient's role just a few times within a specific period of time. Therefore, physicians may follow a fixed pattern because they would know about the positive consequences (Heide and Wathne, 2006). It has been found that customers are more flexible than service providers in the area of informal actions, which can be an example of "behavioral flexibility" (Grayson, 2007).

A critical particularity is noticed in the third cluster of patients under an unfavorable scenario. These patients have significantly higher levels of relationship behavior and higher levels of positive outcomes, even though the physician is negative. There are two possible explanations for this situation: One is that patients engage in more informal behavior when the physician is negative with the hopes of having a better interaction with the doctor. Another possibility is that patients have their own ways of interacting with doctors, and informal behavior may be a major component of this interaction regardless of how the doctor behaves.

Similarly, a specific cluster of physicians continues to invest in the relationship although they engage in less informal behavior in general. This is an outstanding finding about physicians, who would normally engage in almost standard levels of relationship behavior, but who would choose to invest in the relationship even when the patient is uncooperative. In other words, informal behavior for physicians can also serve as a tool when the patient needs to be intensely called back into the relationship. This can also cause strain (Grayson, 2007) because the provider does not focus on service provision, but rather on having the "correct" type of relationship.

It is observed that relationship-building activities and positive outcomes increase and decrease together. Outcomes are affected by the direct effect of the other partner's favorable or unfavorable behavior, which is manipulated through scenarios. However, it is also noticeable that one partner's relationship-building behavior also affects his/her own perception of outcomes (regression models are significant at p-value<.000). Since this study does not look at the actual interactive effects of relationship building, it is not possible to understand whether partners invest in a relationship of which they know the outcomes would be positive, or whether they perceive outcomes as more positive just because they tried hard to build that relationship. This point warrants further attention, because if the latter explanation is true, it may contradict previous accounts which claim that relationship can never replace the core service (Crosby and Stephens, 1987; Wan et al., 2012). Some studies even show that customers may find it quite difficult to choose between a physician with technical expertise and a physician of high interpersonal quality (Fung et al., 2005). Relationships with more expressive characteristics (Johnson et al., 2011) may in fact require a very strong bond between the provider and the customer, and the relationship itself may account for a substantial part of the overall service (Jayanti and Jackson, 1991).

The whole idea of relationship and co-creation is built upon the perspective that customer participation alone cannot create satisfaction, even for customers (Chan et al., 2010). There is slight evidence in this study indicating that (informal) relationship may become a crucial part of the service. As such, a patient may consider having a satisfactory relationship as important as the diagnosis/treatment. It is also suggested in this study that the term "relationship" itself may need to be revisited (Price and Arnould, 1999) because extant literature uses this term to reflect different concepts. Research is needed as to whether calling the consumer by his/her name is a strategically employed transaction gesture (e.g. writing names on coffee cups) or an attempt to establish a relationship bona fide. Co-creation, in this sense, should be discussed within the confines of specific contexts

Findings from this study can be utilized in the healthcare sector. Physicians can attempt to shape their service interactions so that results are satisfactory both for themselves and patients. For instance, they can consider changing the amount of informal behavior when the patient is either positive or negative, increasing

chances for longer-term relationship maintenance. On the other hand, patients can also consider adopting more formal behavior, which might better balance the language, interaction, and dealings between the patient and the doctor. Hospital managers can consider arranging patient-physician interactions by providing optional pre-meeting sessions with patients.

Although health care represents a service with credence attributes and thus an appropriate example for relationship studies, findings need to be validated by repeated measurements in different contexts. In addition, this research has concentrated on one-time single service situations; however, these situations themselves can be categorized into such forms as short service encounters (e.g., fast-food restaurants), longer encounters with outcomes specific to that encounter (e.g., hairdressers), or longer encounters with more enduring outcomes (e.g. healthcare), which are still one-time but with varying characteristics.

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