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IMPACT OF MIXED SERVICE MARKETING PERFORMANCE AND CUSTOMER RELATIONSHIP MANAGEMENT ON PATIENT LOYALTY CASE STUDY: PRIVATE HOSPITAL, BANDUNG

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Abstract

Hospitals must deliver safe, timely, high-quality care while staying efficient and financially sustainable. Because healthcare is a credence service, patients often judge value from what they directly experience—communication, reliability of the service flow, waiting time, and facilities—rather than from technical outcomes. This study examined whether a hospital-adapted 9P service marketing mix and Customer Relationship Management (CRM) are associated with loyalty among corporate clients of a private women-and-children hospital in Bandung that showed declining utilisation and fewer corporate partners over one year. Using an explanatory cross-sectional design, data were collected from 125 employee-patients across 25 partner companies through five-point Likert questionnaires; scores were transformed using the Method of Successive Intervals (MSI) and analysed with descriptive statistics, Pearson correlations, and path analysis ($\alpha = 0.05$). The 9P mix was rated fair-to-good (mean 3.39/5), strongest in staff appearance, professionalism, and core services, but weaker in promotion, price perceptions, punctuality/process reliability, and access cues. CRM was moderate-to-low (mean 2.85), with strong interpersonal communication but limited correspondence and rewards/privileges. Loyalty was moderate (mean 3.07): intention to return, cross-service use, and willingness to recommend were relatively strong, yet revisit frequency and feedback to management remained lower, indicating an intention–behaviour gap. In the path model, 9P significantly predicted loyalty ($\beta = 0.491$), whereas CRM did not ($\beta = 0.064$); together they explained 29.1% of loyalty variance ($R^2 = 0.291$). The main implication is to improve point-of-care reliability first, then systematise CRM through scheduled follow-up, documented service recovery, and practical corporate benefits.

Keywords: service marketing mix (9P); customer Relationship Management (CRM); patient loyalty; corporate clients; hospital services; path analysis; Method of Successive Intervals (MSI).

1. INTRODUCTION

Hospitals are expected to provide safe, timely, high-quality care while staying efficient and financially stable. This is getting harder because healthcare is a credence service: many patients cannot judge technical quality directly, so they rely on what they experience—clear communication, reliable service flow, and the physical setting—when deciding whether care feels valuable (Kruk et al., 2018; OECD, 2023a; NHS England, 2025).

In Indonesia, changes in public financing and a stronger market orientation have increased pressure on hospitals to expand access and improve efficiency without

reducing quality or safety (Depkes RI, 2008; Kotler & Keller, 2009). Performance is often tracked through indicators such as Bed Occupancy Rate (BOR), Length of Stay (LOS), Turn Over Interval (TOI), Bed Turn Over (BTO), Gross Death Rate (GDR), and Net Death Rate (NDR), alongside patient satisfaction and financial viability (Depkes RI, 2007; Indradi, 2010). Because care is delivered and consumed in real time, the service process—waiting time, staff responsiveness, clarity of information, and facilities—can influence patient behaviour as much as clinical outcomes (Kurtz & Clow, 1998; Lovelock & Wright, 2002/2005; Arief, 2006).

For this reason, hospital marketing is not just about promotion. Services marketing typically extends the mix beyond 4P to include people, process, and physical evidence; in healthcare, adding professionalism and performance is also useful because they reflect clinical governance and day-to-day discipline (Hurriyati, 2005; Sabarguna, 2005, 2006; Kotler & Keller, 2006, 2009). Ethical limits are equally important: overly aggressive promotion can weaken trust, so communication should remain patient-centred and evidence-based (Elrod & Fortenberry, 2020; OECD, 2023b; OECD, 2025).

This study focuses on a private women-and-children hospital in Bandung that, over one year, showed declining bed occupancy, lower outpatient volume, and fewer corporate partners. These signals point to gaps not only in communication, but also in service reliability and relationship handling. The study therefore tests whether performance on a hospital-adapted 9P marketing mix and perceived Customer Relationship Management (CRM) practices relate to patient loyalty among corporate clients, with the aim of identifying practical priorities that can turn positive attitudes into consistent repeat behaviour.

2. LITERATURE STUDY

Service marketing puts the customer at the centre of value creation. In practice, it is not only about "selling," but about planning the service, setting fair prices, communicating the offer, and making the service available through the right channels so the organisation and its stakeholders can reach their goals (Kotler & Keller, 2009; Berkowitz, 1996; Lovelock & Wright, 2002). This way of thinking fits healthcare, because patients usually judge hospitals from what they can see and feel during the service, not only from clinical results. Many parts of care are "experienced" in real time—how staff speak, how smooth the flow is, how long waiting takes, and what the environment looks like (Kurtz & Clow, 1998; Hurriyati, 2005; Arief, 2006). Hospitals therefore compete not only through "what they provide", but also through "how the service feels" during the patient journey (Lemon & Verhoef, 2016).

Because of that, the classic 4P mix (product, price, place, promotion) is often expanded in services into 7P by adding people, process, and physical evidence (Booms & Bitner, 1981; Kotler & Keller, 2006). In hospital contexts in Indonesia, the mix is often expanded further into 9P by adding professionalism and performance, because hospitals must show credibility, ethics, and disciplined results, not just friendly service (Hurriyati, 2005; Sabarguna, 2005, 2006). This expanded view matches health service quality thinking that separates what supports care (structure), how care is delivered (process), and what results are achieved (outcome) (Donabedian, 1988). In short, 9P helps a

hospital describe what it offers, how it delivers the service, and how well it keeps its promises.

Conceptually, each dimension of the 9P contributes in a specific way to perceived quality and perceived value. Product/service refers to the clinical portfolio, patient safety, and how complete the services feel for the patient's needs. Price is not only about the number on the bill; it also signals tariff transparency, financing options, and whether patients feel the value matches the cost (Depkes RI, 2008). Place covers access: location, service hours, and channels such as call centres or teleconsultation that make care easier to reach. Promotion in healthcare should be seen mainly as ethical communication and education, aligned with public guidelines, rather than aggressive selling (Depkes RI, 2007; Elrod & Fortenberry, 2020). People refer to staff competence and empathy, because patients often remember how they were treated as much as what was done clinically (Arief, 2006). Process reflects the service pathway—from registration to clinical service, to pharmacy, to payment, and follow-up—guided by clear SOPs. Physical evidence shapes perception through cleanliness, comfort, layout, signage, and general order in the facility (Bitner, 1992).

The added dimensions professionalism and performance make the expanded mix more suitable for hospitals because they capture two things' patients and corporate partners care about most: clinical credibility and operational reliability. Professionalism reflects credentialed staff, ethical conduct, adherence to clinical standards, and governance mechanisms such as medical committees, clinical by-laws, and continuing professional development. Performance reflects punctuality, accuracy, consistency, and smooth coordination across units—issues that corporate clients notice because they need predictable service and simple administration (Sabarguna, 2006; Indradi, 2010; Rowland & Rowland, 1984). This focus is also consistent with service-quality measurement research: the Service Quality model (SERVQUAL) measures service quality from customer perceptions (Parasuraman, Zeithaml, & Berry, 1988), while the Service Performance model (SERVPERF) shows that perceived performance scores alone can strongly predict behavioural outcomes (Cronin & Taylor, 1992). Therefore, patient-rated 9P performance is a reasonable predictor of loyalty.

However, marketing mix performance alone may not be enough to keep customers over time. In services, long-term success often depends on relationships. Customer relationship building is seen as a strategic need: creating mutual value, maintaining two-way communication, and offering more personalised service so customers want to stay (Brown, 2000; Anton & Petouhoff, 2002; Peppers & Rogers, 2004). CRM is the practical approach that integrates people, processes, and technology to acquire customers, retain them, and develop the relationship over time (Anton & Petouhoff, 2002; Payne & Frow, 2004). In hospitals—where services are high-risk and information is unequal between provider and patient—trust and commitment become critical (Morgan & Hunt, 1994). They reduce perceived risk and make customers less likely to switch when other options appear (Hajikhani et al., 2015; Yaghoubi et al., 2017).

Customer loyalty is usually defined as repeated, non-random purchasing behaviour that is supported by a positive attitude toward the provider. Loyalty is valuable because it can reduce marketing costs, increase cross-service use, generate positive word of

mouth, and lower churn (Griffin, 2003; Alma, 2004). In complex services like healthcare, corporate image can strengthen the impact of quality and satisfaction on loyalty, especially for customer groups that are more knowledgeable or experienced in using services (Andreassen & Lindestad, 1998; Oliver, 1999). Healthcare marketing literature also stresses that technical quality (clinical competence) must go together with functional quality (empathy, clarity of information, fairness in handling complaints). When both are strong, perceived value rises and loyalty becomes more stable (Dwyer et al., 1987; Lovelock & Wright, 2002/2005; Arief, 2006).

This study places service marketing mix performance (9P) and customer relationships/CRM as direct predictors of loyalty in the corporate client segment. The 9P mix helps the hospital deliver a consistent value promise—through the offer, pricing/financing, access, ethical communication, human resources, processes, physical environment, professionalism, and performance. CRM helps ensure that the promise is felt as personal, responsive, and continuous over time, not only during the visit. National policies and guidelines (accreditation rules, health promotion guidance, financing programs) act as institutional boundaries that keep strategies ethical and compliant (Depkes RI, 1994, 2007, 2008).

Based on the discussion above, three hypotheses are proposed for testing in the hospital context: (1) service marketing mix performance (9P) has a positive effect on customer loyalty; (2) customer relationships/CRM have a positive effect on customer loyalty; and (3) service marketing mix performance (9P) and customer relationships/CRM simultaneously have a significant effect on customer loyalty.

3. METHODOLOGY

3.1 Study Design and Setting

This study is grounded in services marketing, where value is created through a combination of service design, delivery, and the customer's lived experience across the service journey in a private hospital in Bandung, Indonesia. In hospital settings, the marketing mix is often expanded from the classic 4P to a context-specific 9P, incorporating product/service, price, place, promotion, people, process, physical evidence, professionalism, and performance (Lovelock & Wright, 2002; Hurriyati, 2005; Kotler & Keller, 2006, 2009; Sabarguna, 2005, 2006). The additional elements—professionalism and performance—are particularly relevant for hospitals because they reflect clinical governance, operational discipline, and credibility in services that patients cannot easily evaluate technically (Rowland & Rowland, 1984; Depkes RI, 1994, 2003, 2006, 2007; Indradi, 2010; NICE, 2021).

Alongside the marketing mix, CRM in healthcare refers to coordinated practices that strengthen long-term relationships, including interpersonal communication, service recovery, follow-up, and systematic outreach supported by processes and information systems (Brown, 2000; Anton & Petouhoff, 2002; Barnes, 2003; Peppers & Rogers, 2004). In principle, strong delivery on the 9P should be associated with higher loyalty, and CRM should add incremental influence by strengthening trust and commitment (Andreassen & Lindestad, 1998; Griffin, 2003; Alma, 2004; Rangkuti, 2004; Lemon & Verhoef, 2016; Payne et al., 2017).

Three constructs were examined in this contribution, namely (1) X_1 (Service marketing performance/9P) depicts patient perceptions across nine dimensions of hospital service delivery; (2) X_2 (CRM practices) describes perceived relationship-building efforts such as contact, preferential treatment, and structured engagement; and (3) Y (Patient loyalty) explains repeat intention and behaviour, cross-service uptake, resistance to switching, and word-of-mouth.

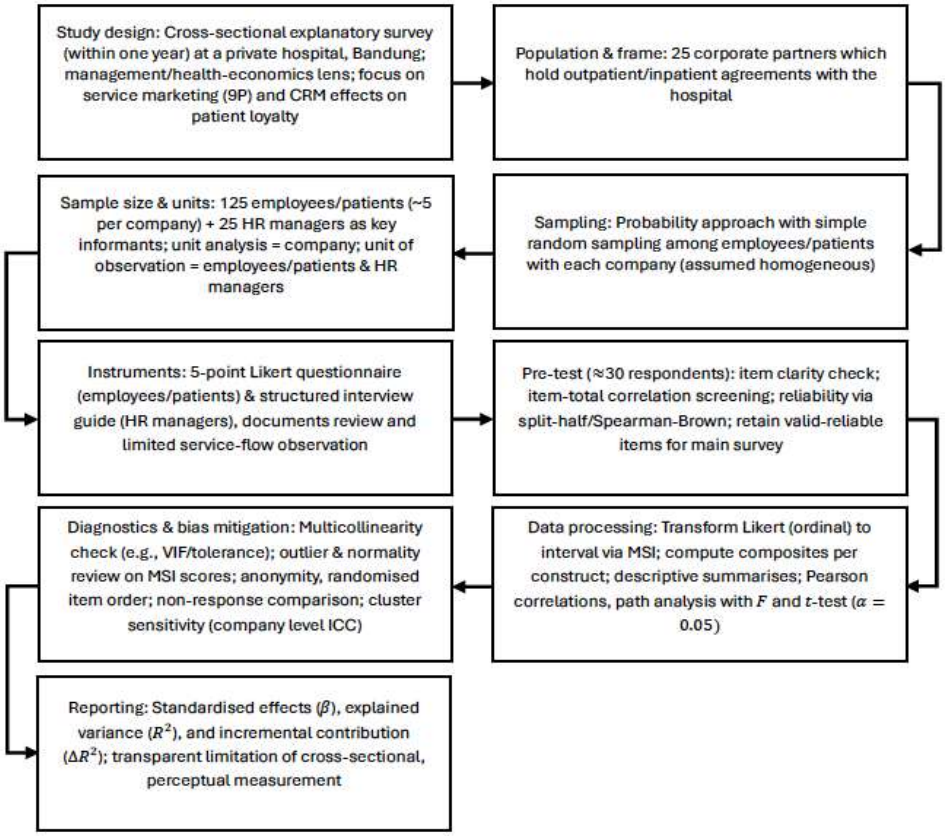
3.2 Design, Population, and Sample

This study used an explanatory cross-sectional survey with a descriptive–verificatory approach, conducted over one year in the hospital's corporate client segment. The sampling frame covered 25 partner companies with outpatient and/or inpatient agreements. Within each company, employee-patients were selected using simple random sampling, and HR managers were included as key informants to provide organisational context. The final sample consisted of 125 employee-patients (about five per company) and 25 HR managers, which is consistent with common guidance for correlation and path analysis (Westland, 2015; Hair et al., 2022; Kline, 2023).

Most employee respondents were women (60%) aged 31–40 (52%); nearly all were married (96%), many held a bachelor's degree (59%), and most worked in private firms (64%) or state-owned enterprises (32%). About 62% earned more than IDR 5 million per month, suggesting a middle-to-upper segment. In terms of service use, paediatric outpatient care was most common (77.6%), followed by obstetric outpatient care (53.6%) and paediatric inpatient care (28.8%). Most had used the hospital at least twice (around 74%), giving them enough experience to assess service consistency. The main reasons for choosing the hospital were strategic location (76%), a perceived strong hospital–company/patient relationship (72%), service quality and variety (56%), and procedural convenience (53%), while price (16%) and promotion (3%) played a smaller role in initial choice.

3.3 Instruments, Data Quality and Analysis

Figure 1 summarises the design and sampling workflow—from frame construction and respondent selection to instrument development, data processing and analysis. To support this study, data were collected using a five-point Likert questionnaire for employee-patients, a structured interview guide for HR managers, and documentation review and limited observation to contextualise service-flow issues. A pilot test from 30 respondents was used to check item clarity. Item screening relied on item–total correlations, and reliability was evaluated using split-half reliability (Spearman–Brown).



Because path analysis commonly assumes interval data, Likert (ordinal) scores were converted using the Method of Successive Intervals (MSI) and then aggregated into construct scores. This approach is often used when researchers treat Likert-type responses as approximately interval for parametric modelling, with appropriate caution (Harpe, 2015).

Figure 2 presents the measurement and structural model: 9P and CRM are specified as exogenous predictors of loyalty, with covariance permitted between 9P and CRM to recognise their operational interdependence. In this logic, stronger delivery on the 9P should align with higher loyalty, and well-orchestrated CRM should add incremental explanatory power by deepening trust and commitment beyond operations alone.

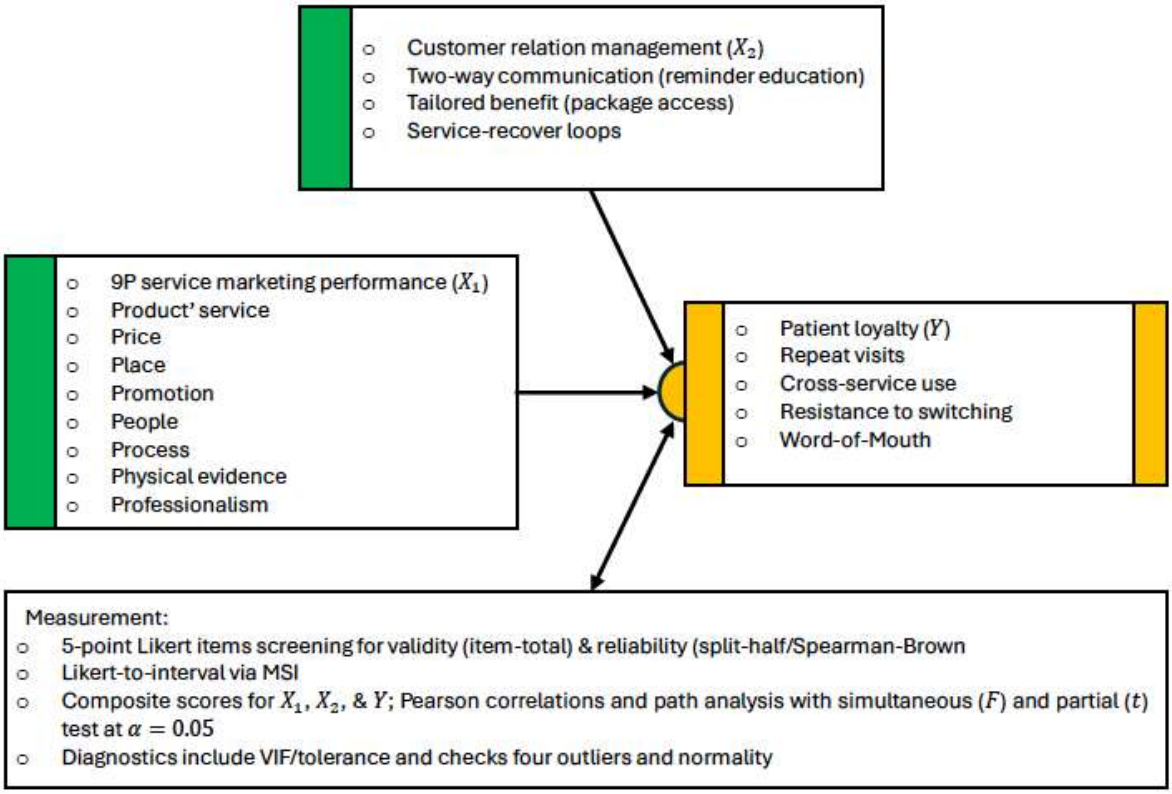


Figure 2. Measurement and structural model

Analysis proceeded in three stages: (1) descriptive statistics summarised central tendency and dispersion of each 9P, CRM dimension, and loyalty dimension (MSI-transformed); (2) Pearson correlations among X_1 (9P), X_2 (CRM), and Y (loyalty); and (3) Path analysis to estimate direct effects of 9P → loyalty and CRM → loyalty, as well as the combined explanatory power (R^2). Simultaneous (F) and partial (t) tests used $\alpha = 0.05$, and results were reported as standardised coefficients (β) and ΔR^2 to quantify the incremental contribution of CRM beyond 9P, following established practice (Hair et al., 2022; Kline, 2023; Hayes, 2018).

Diagnostic checks included multicollinearity (e.g., VIF/tolerance), outliers, and approximate normality of MSI scores. To reduce common-method bias, questionnaires were anonymised, and item order was randomised; limitations of cross-sectional self-report data were acknowledged in interpretation (Yao et al., 2024).

4. RESULT AND DISCUSSION

This study tested three hypotheses: H1 that service marketing mix performance (9P) positively affects patient loyalty; H2 that CRM positively affects patient loyalty; and H3 that 9P and CRM together have a significant effect on loyalty. The descriptive results and the path model help explain which parts of the service experience matter most for corporate patients and where improvements should be focused.

4.1 Service Marketing Performance (9P)

Overall, as it is shown in Table 1, patients rated the hospital's 9P performance as fair-to-good (mean 3.39/5). The strongest areas were staff appearance (3.65), professionalism (3.54), and core services/product (3.54). This suggests that patients generally trust the

frontline presentation and clinical credibility cues they see during visits. Several dimensions were in the middle range—place (3.40), process (3.35), and physical evidence (3.33)—meaning access, service flow, and the facility environment were acceptable but not outstanding.

Table 1. Distribution of Mean Scores for Service Marketing Mix Variables — the Private Hospital, Bandung

Dimension	Score	Percentage (%)
Product	3.54	70.4
Price	3.27	65.5
Place	3.40	68.1
Promotion	3.14	63.0
People	3.29	66.0
Process	3.35	67.1
Physical evidence	3.33	66.8
Staff professionalism	3.54	71.0
Staff appearance	3.65	73.0
Mean score (overall)	3.39	

The lowest score was promotion (3.14), and it was also weak relative to the other "P" elements. A likely reason is limited online outreach and social media communication, so patients do not consistently receive updates about new programs, service packages, or service improvements. When patients do not see these updates, innovations are less visible and the hospital has fewer chances to trigger demand, especially for corporate users who often plan care around work schedules.

4.2 Customer Relationship Management (CRM)

Table 2 shows that CRM was rated moderate-to-low overall (mean 2.85). Interpersonal communication scored relatively well (3.57), indicating that frontliners and clinicians were perceived as polite and empathic. However, more structured relationship practices were weak—particularly reward/privilege (2.26) and customer correspondence (2.62). In other words, CRM existed primarily as individual interpersonal quality, not as a coordinated system of outreach, retention, and service recovery.

Table 2. Mean Scores for Customer Relationship Variables — the Private Hospital, Bandung

Dimension	Score	Percentage (%)
Customer correspondence (direct mail)	2.62	52.4
Preferential treatment	2.97	59.4
Interpersonal communication	3.57	71.4
Reward/privilege	2.26	45.2
Mean score (overall)	2.85	

This pattern implies that CRM exists mainly as a good personal interaction at the point of care, not as a structured program that keeps contact with patients between visits. For corporate clients, this matters because they tend to value predictable communication—reminders, follow-up, and clear channels for coordination—so weak outreach can limit how far a good visit translates into repeat behaviour.

Managerially, the implication is that CRM improvement should focus on systematisation rather than interpersonal tone: establishing scheduled touchpoints (reminders and follow-ups), simple corporate benefits (e.g., streamlined access or administrative support), and a clear service-recovery loop. These steps would strengthen the lowest-rated dimensions and make CRM function as a retention mechanism rather than only a courtesy experience.

4.3 Patient Loyalty

Result of Table 3 shows that patient loyalty was rated moderate (mean 3.07). Loyalty was strongest in intention to revisit, use of multiple service types, word-of-mouth willingness, and some resistance to switching. However, it was limited by lower indicators of revisit behaviour and minimal feedback to management.

Table 3. Summary of Customer Loyalty Level — the Private Hospital, Bandung

Dimension	Score	Percentage (%)
Frequency of revisit	2.88	57.6
Frequency of intention to seek treatment	3.36	67.2
Frequency of providing suggestions to hospital management	2.63	52.6
Frequency of recommending the hospital to others	3.20	64.0
Frequency of using multiple service lines	3.22	64.4
Frequency of resistance to switching hospitals	3.14	62.8
Mean score (overall)	3.07	

The loyalty pattern is consistent with the earlier 9P and CRM results. Strong staff appearance/professionalism (Table 1) and good interpersonal communication (Table 2) likely support higher intention to seek treatment (3.36), cross-service use (3.22), and recommendations (3.20), reflecting trust in frontline care. However, weaker 9P areas—promotion, pricing perceptions, punctuality/process reliability, and access constraints (e.g., parking)—may help explain the lower actual revisit frequency (2.88), producing an intention–behaviour gap. Because CRM remains weak in correspondence and rewards/privileges, patients also receive limited follow-up and have fewer channels or incentives to engage between visits, which aligns with low feedback to management (2.63). Overall, improving operational reliability while systematising CRM follow-up and feedback routines is the clearest route to converting positive intentions into stronger behavioural loyalty.

4.4 Path Analysis and Statistical Test

The statistical model clarifies which hypotheses are supported. The 9P composite had a moderate correlation with loyalty ($r = 0.538$) and a positive, significant direct effect on

loyalty ($\beta = 0.491,\ t = 4.409,\ \alpha < 0.05$)). This supports H1: better perceived 9P performance is associated with stronger loyalty. CRM had a weaker correlation with loyalty ($r = 0.422$) and a small, non-significant direct effect ($\beta = 0.064, t = 0.579$), so H2 is not supported in the direct-effect form used here. The two predictors were strongly related ($r = 0.729$), which suggests CRM is connected to operational quality in practice, even if it does not show an independent effect once 9P is already in the model. Together, 9P and CRM explained 29.1% of loyalty variance ($R^2 = 0.291$)— with total contributions of around 26.4% for 9P (direct 24.1%; indirect via CRM 2.3%) and around 2.7% for CRM (direct 0.4%; indirect via 9P 2.3%), meaning H3 is supported: jointly, they significantly relate to loyalty, although most explanatory power comes from 9P rather than CRM.

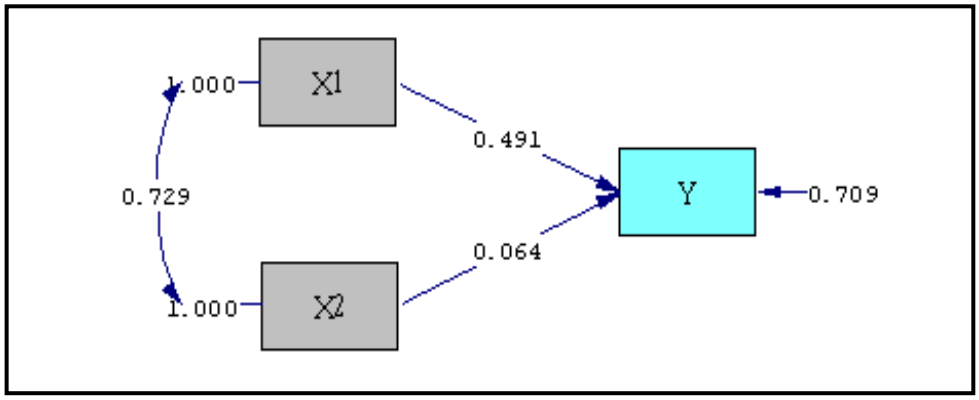


Figure 3. Path Diagram and Path Coefficients of the Effects of Service Marketing Mix Performance (X_1) and Customer Relationship Management (X_2) on Customer Loyalty (Y)

4.5 Managerial and Operational Implications

Substantively, these findings imply that for corporate patients, loyalty is driven mainly by what they feel directly in the service encounter—especially the "operations-close" elements such as people, process, physical evidence, professionalism, and performance. CRM adds little on its own when it is not integrated into daily operations, but it can become a useful booster when it supports the core service spine through consistent follow-up and service recovery. This points to two improvement tracks that must run together.

On the 9P operations track, priority should be service reliability and ease: improve clinician on-time performance with better scheduling and backup planning, reduce friction in patient flow through simpler Standard Operational Procedures (SOPs) and digital pre-visit intake, and address access cues such as parking while maintaining cleanliness and comfort.

Pricing and payment can be made more corporate-friendly through clearer packages and flexible settlement aligned with coverage limits. Promotion should shift from broad messaging to targeted, journey-based communication so corporate patients receive timely updates before and after care. On the CRM track, the priority is systematisation: scheduled reminders and follow-ups (SMS/WhatsApp/email), documented service recovery, simple practical benefits, and stronger voice-of-customer tools such as QR micro-surveys after visits. Taken together, these steps are the most direct route to

convert positive intentions into more consistent repeat behaviour and stronger loyalty over time.

5. CONCLUSION & RECOMMENDATION

5.1 Conclusion

This study found that the hospital's service marketing performance (9P) was rated fair-to-good, while CRM and patient loyalty were moderate. Patients gave the highest scores to visible, front-line cues—staff appearance, professionalism, and polite communication—which aligned with stronger loyalty attitudes such as intention to return, willingness to recommend, and use of multiple services.

However, weaker areas in promotion, price perceptions, process reliability/on-time performance, and access (e.g., parking) likely contributed to an intention–behaviour gap: revisit frequency and feedback to management remained relatively low. The path model supports this pattern: 9P had a significant direct effect on loyalty ($\beta = 0.491$), while CRM had a small and non-significant direct effect ($\beta = 0.064$), though together they explained 29.1% of loyalty variance. Overall, loyalty among corporate patients is mainly driven by reliable service delivery, with CRM acting as a supporting factor when it is closely tied to daily operations.

5.2 Recommendations and Future research

For practice, the first priority is to strengthen operational reliability—especially scheduling punctuality, smoother patient flow, and access convenience—while improving price clarity and more targeted, digital-friendly communication. CRM should be redesigned as a consistent system rather than informal courtesy, focusing on scheduled follow-ups, reminders, documented service recovery, simple corporate-friendly benefits, and easy feedback channels (e.g., QR post-visit surveys). For future research, longitudinal designs are recommended to separate intention from actual repeat behaviour and to test additional drivers of loyalty such as satisfaction, perceived value, trust, waiting time, hospital image, and administrative convenience. Future studies can also compare results across payer types and service lines, and test whether CRM works better as a mediator/moderator or when measured with more objective indicators (e.g., follow-up rates, complaint resolution time, and retention metrics).

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