Predictors of customer engagement in the South African open medical aid industry

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ABSTRACT

The South African open medical aid industry is faced with the challenge of customers losing confidence in their services and switching to another open medical aid provider. The South African open medical aid industry is seen as a very competitive industry, therefore it is imperative for open medical aid providers to pursue the development of customer engagement in order to help them to distinguish themselves from competitors and preventing their customers from switching to another open medical aid provider.

The literature review revealed that open medical aid providers need to improve their customer engagement to ensure sustainability. As a result, the primary objective of this study was to determine the predictors of customer engagement in the South African open medical aid industry.

The study executed a descriptive quantitative research design, and used non-probability convenience and quota sampling to obtain data from consumers who reside in the three selected cities in the North West Province, who are a member of one of the five major open medical aid providers, who are the primary or principal member, and who have been a member for two or more years. A self-administered questionnaire was distributed to public and high traffic areas, resulting in a total of 307 usable questionnaires. The data analysis involved assessing the reliability and validity of the measurement scales, the calculation of descriptive statistics, as well as the calculation of inferential statistics in the form of a standard multiple regression.

The main findings of the literature review were reported in Chapter 5. The measurement scales that were used to measure the constructs of the study were determined reliable and valid. In addition, trust, affective commitment, and perceived value were found to have a significant positive impact on customer engagement, with service quality having the greatest impact. Therefore, it is recommended that open medical aid providers should focus on enhancing customer trust, affective commitment towards their service, perceived value, as well as the quality of their services.

Future research should address the methodological and other limitations of this study, by extending the research to gain the opinion of respondents from more cities in other Provinces in South Africa. In addition, future research can focus on investigating the differences in scores of different demographic group.

LIST OF KEY TERMS

Affective commitment

Johnson *et al*. (2008:353) define affective commitment as the customer's emotional attachment to a business, the customer's sense of belonging, as well as the customer's identification with the business. According to De Ruyter *et al*. (2001:272), affective commitment reflects the degree to which customers like to sustain a business relationship. In a consumption relationship, customers start to gain an emotional attachment to a business, which is seen as the principle of affective commitment (Fullerton, 2003:334).

Customer engagement

Sashi (2012:256) defines customer engagement as a process that advances over the development of a relationship. According to Van Doorn *et al*. (2010:253), customer engagement is considered a behavioural construct that goes further than buying behaviour. Hollebeek (2011:565) describes customer engagement as the level of a customer's rational, emotional, as well as behavioural speculation in a particular product or service interaction.

Customer satisfaction

Farris *et al*. (2010:56) refer to customer satisfaction as a promoting term that measures whether or not products or services meet or exceed a customer's expectations. Fornell (1992:11) considers customer satisfaction as the customer's complete post-purchase assessment. Anderson *et al*. (1994:55) state that customer satisfaction is not only based on the customer's current experiences, but also on previous, and future (or expected) experiences.

Customer trust

Mayer *et al*. (1995:712) define customer trust as a customer's willingness to be exposed to the activities of a business based on the hope that the business will execute a certain activity that is important to the customer, regardless of the customer's capacity to monitor or regulate the business. According to Morgan and Hunt (1994:23), trust occurs when a customer has confidence in the business' reliability and integrity

Perceived value

Zeithaml (1988:14) defines perceived value as the customer's general evaluation of the effectiveness of the business' product, based on the perception of what was received and what was given.

Service quality

Service quality is a pertinent component of relationship marketing and services marketing, and is used to determine how well the customer's expectations are matched by the service provided (Parasuraman *et al*., 1985:42). Service quality is a form of attitude, linked with satisfaction, which results from the comparison of the customer's service expectations with the performance of the business (Cronin & Taylor, 1992:56). According to Parasuraman *et al*. (1988:23-24), and Saghier and Nathan (2013:3), service quality involves five dimensions, namely tangibles, reliability, responsiveness, assurance, and empathy.

Medical aid provider

According to Fedhealth (2019a), a medical aid provider is a form of insurance where the customer pays a monthly premium in return for financial cover for medical treatment or related medical expenses that the customer might require.

Open medical aid provider

An open medical aid is a supplier of medical coverage that is available to anyone who wishes to become a member, regardless of their age, education or health status (Francis, 2013; SA Medical Aids, 2017).

Relationship marketing

Morgan and Hunt (1994:22) state that relationship marketing refers to all the marketing activities that rely on positive relationship exchanges. According to Navarro *et al*. (2004:426), these exchanges can generate value, enabling a business to reach a maintainable competitive position. In simpler terms, relationship marketing is a way of recognising, creating, sustaining, as well as enhancing long-term relationships with customers by encouraging customer loyalty and refining the way of doing business, in order to achieve the business goals (Madhavaiah & Rao, 2007:75)

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CHAPTER 1: INTRODUCTION TO THE STUDY

1.1 Introduction

The aim of this study was to determine the predictors of customer engagement in the South African open medical aid industry. In order to achieve this, the influence of selected relationship marketing constructs (i.e. customer satisfaction, trust, affective commitment, perceived value, and service quality) on customer engagement was investigated.

This chapter commences with a discussion of the background and research problem, followed by an overview of the South African open medical aid industry. Furthermore, a literature review is provided on the constructs, as well as a discussion on the relationships between the constructs. Thereafter, the conceptual framework, followed by the research objectives, which consist of a formulation of the primary and secondary objectives, and hypotheses. Lastly, a discussion of the research methodology and the chapter classification are provided.

1.2 Background and research problem

For many South Africans, gaining access to quality healthcare services is nearly an impossible task as they have to struggle with deprived services in the public healthcare sector or expensive medical bills from private healthcare services (Burger & Christian, 2018:11; BusinessLIVE, 2018). According to Brand-Jonker (2019a), one of the key findings of studies on the private healthcare industry is that expenses continue to increase without actual changes in health results. According to Jensen (2017), the main reason why individuals join a medical aid provider is to obtain support in paying for their medical expenses. Since customers are continuously searching for quality products and services (Mosadeghrad, 2014:77), medical aid providers are under significant pressure to constantly attempt to improve their service offerings (Kaplan & Ranchod, 2015:114).

By improving the quality of their services, medical aid providers can reduce costs, increase market share and establish a positive business image (Mosadeghrad, 2014:77-78), which should, in turn, result in higher productivity and profitability (Alexander *et al*., 2006:1004; Arora & Narula, 2018:31). Subsequently, it is critical to accurately describe, measure and ultimately enhance the quality of healthcare services (Mosadeghrad, 2014:78).

The results of research conducted by The Competition Commission (2016:7) indicated that customers experience difficulty in choosing a medical aid provider as well as understanding the associated legislative information and terminology. According to the research of Erasmus (2015) and Jensen (2015), customers want their medical aid providers to listen to them, help them understand the terms and conditions, and also continuously provide them with reliable feedback. However, according to Jensen (2015), medical aid providers still fail to sufficiently pay attention to the core of their business (i.e. customers), such as the call centres that interact with their customers on a daily basis, which might be because some medical aid providers have grown so big that it has become difficult for them to continue a personal and human connection while interacting with their customers. As it has been established that sustainable and long-lasting customer relationships can increase customer satisfaction, lead to customer loyalty and retention, and ultimately increase the profitability of the business (Hassan *et al*., 2015:567; Lombard, 2011:3488; Xaluva, 2012:30-31), it is important that medical aid providers aim to establish and maintain relationships with their customers. Open medical aid providers can use customer engagement to establish and maintain these relationships by keeping customers actively involved (Tripathi, 2009:133). Brodie *et al*. (2011:2) indicate that engaged customers are more inclined to provide referrals or recommend the open medical aid provider's service to others.

According to Bisschoff and Clapton (2014:45), customers associate most medical service encounters with worry, pain, risk, and sometimes embarrassment, and therefore tend to view these encounters as negative experiences. In addition, South Africa's medical aid industry has been rated as one of the lowest when it comes to overall satisfaction, due to complex rules, exclusions, co-payments and the fact that medical aid providers are one of South Africa's most expensive monthly expenditures (BusinessTech, 2017a; Netwerk24, 2018). The results of the SAcsi (South African Customer Satisfaction Index) – used to survey more than 3 000 members of South African medical aid providers – also revealed that the majority of South Africans are unsatisfied with their medical aid provider (Consulta, 2019; Medical Plan Advice, 2015).

Jensen (2015) notes that complaints regarding medical aid providers can be divided into two broad categories namely benefit complaints (20%) and service complaints (80%). In any medical aid call centre environment, one of the most challenging areas in striving for customer satisfaction is most likely trying to resolve benefit-related complaints, as the customer may not always be fully aware of all the benefits or shortfalls, and the rules of the

medical aid provider (Jensen, 2017). Benefit-related complaints include day-to-day cover, medicine, and major medical costs, while service-related complaints are motivated by perceived quality, value, and service expectations (Jensen, 2017; IHS, 2012).

Statistics gathered by the WHO (World Health Organisation) demonstrate that the majority of South Africans rely on the public healthcare industry for their healthcare needs (BusinessLIVE, 2018; KeyHealth Medical Aid, 2015). Approximately nine million South Africans out of a population of 59 million are able to afford private healthcare (BusinessTech, 2019b; IRR, 2016:8). Therefore, without medical aid providers, the public healthcare industry was placed under even more pressure, as it does not have the capacity to serve more customers (Brand South Africa, 2012; KeyHealth Medical Aid, 2015; UCT GSB, 2018; Van Zyl, 2015). Medical aid providers contribute approximately R130 billion every year to their beneficiaries, and without their contribution, more than 90% of their beneficiaries would not be able to afford private healthcare (KeyHealth Medical Aid, 2015a). Most South Africans overlook the importance of a medical aid provider, assuming they will have enough money to pay for their medical expenses (Fin24, 2017). Without medical aid, private hospitals may require a 50% deposit of the projected cost, which can be thousands or even hundreds of thousands of rands (Fedhealth, 2019b), and if the deposit cannot be paid, the patient will be taken to a government hospital and placed in the queue with many others (Van Zyl, 2015). That is why medical aid is important, because it can prevent customers from having to pay such an unforeseen amount and receive treatment quickly (Fedhealth, 2019b). Medical aid providers are considered expensive, and are often regarded as a resentment purchase (CMS, 2019:1; Erasmus, 2015; Schreuder, 2016). However, it is a necessity as it protects customers during unforeseen circumstances (Van Zyl, 2015).

Based on the abovementioned discussion, it is clear that medical aids are important; however, there are problems and dissatisfaction within the industry that require attention. Therefore, selected relationship marketing constructs (i.e. customer engagement, customer satisfaction, trust, affective commitment, perceived value, and service quality) have been selected to be investigated in this study.

1.3 Industry overview

This section provides an overview of the South African medical aid industry as part of the private healthcare industry, as well as an overview of the open medical aid industry. This is followed by distinguishing between open and restricted medical aid providers, identifying the

major open medical aid providers in South Africa, and indicating the current trends and challenges in this industry.

1.3.1 The South African healthcare industry

The healthcare industry of South Africa is defined as a health funding system designed to collect capital to offer South Africans general access to reasonably priced and reliable healthcare services (Department of Health, 2015:9). South Africa consists of private and public healthcare industries (Burger & Christian, 2018:2). South Africa has one of the most expensive private healthcare systems in the world and consists of healthcare specialists who deliver their services on a private basis (Benatar *et al*., 2017:11; Ngoepe, 2016). These services are provided by private hospitals and are usually covered by medical aid providers, who are one of the main providers of financing in private healthcare (Burger & Christian, 2018:2). Two main types of medical aid options exist in South Africa, namely open medical providers and restricted medical providers (Erasmus, 2016b). According to Ngoepe (2016), 41.8% of South Africa's total health expenditure is spent on private healthcare, which is more than any OECD (Organisation for Economic Co-operation and Development) country. Given the fact that approximately R112.6 billion is spent annually on healthcare, it still remains unproductive and the majority of the population does not have access to private healthcare (Nicolaides & de Beer, 2017:2). The public healthcare industry, on the other hand, is financed by the government (Conmy, 2018:2; Young, 2016:2). Approximately 86% of healthcare services in South Africa are provided through the public healthcare industry; however, the South African government only covers 50% of the healthcare expenditure (Health Policy Project, 2016:1; Wasserman, 2019). Public healthcare funding is a crisis in South Africa (IRR, 2018:2; Tshabalala, 2015:24). This crisis is unavoidable, due to the Department of Health's suspending of vacant posts, doctors and nurses in order to cut costs (IRR, 2018:2; Nkosi, 2019).

According to Goldberg (2012) and Maphumulo and Bhengu (2019:2), the public healthcare system is associated with being low on safety, service delivery, shortage of healthcare professionals, patient management, availability of stock and contagion control due to this lack of funding. Additional factors, such as the economic recession, have also had a negative impact on South Africa's healthcare system (Tshabalala, 2015:25). Data from the National Health Accounts showed that, from 1997, there has been a decrease in the public healthcare per capita funding, an increase in discrimination in local resource distribution, as well as a decline in per capita funding of public healthcare (Tshabalala, 2015:24-25).

Groenewald (2017) states that South Africa spends an estimated GDP (gross domestic product) of 8.8% on healthcare annually.

Statistics published by the Institute of Race Relations (IRR) showed that the majority of South Africans do not have medical aid cover (BusinessTech, 2016c; Ellis, 2017) due to the related price and costs. Furthermore, it is shocking to report that only 16.4% of approximately 59 million South Africans have some form of medical aid cover (BusinessTech, 2019a; IRR, 2016:8). This means that the remaining 83.6% (47 million South Africans) do not belong to a medical aid provider and prefer to pay for medical services out of their own pockets or rely on public healthcare for medical assistance (BusinessReport, 2019; IRR, 2016:8). However, many of those without medical aid cover still prefer to use the private healthcare system and pay for the treatment themselves, rather than to rely on an inadequate public healthcare system with long waiting periods and poor standards of treatment (IRR, 2016:8).

South Africa has approximately 4 200 public hospitals and approximately 13 718 patients visit these hospitals daily, which exceeds the World Health Organisation's guideline (Ellis, 2017). According to Tshabalala (2015:1), lower quality services are being delivered due to the government's lack of funding, which places public healthcare under more pressure. Private healthcare is becoming a resentment purchase as more and more customers are starting to complain about the value they receive from their medical aid providers (BusinessTech, 2019d). Results from SAcsi showed that the value score of the medical aid industry has declined from 74.2 in 2017 to 72.7 in 2018 (Bizcommunity, 2018). This means that the lack of value from medical aid providers has had a undesirable effect on overall customer satisfaction. In most cases, customers who complain are usually the ones who pay their monthly contributions, yet they hardly experience the value of financial cover in the case of an accident, illness or disease (Jensen, 2017). According to Bizcommunity (2018) and Schreuder (2016), medical aid providers are not providing sufficient financial protection, as patients are still required to make substantial co-payments; however, the contribution levels of medical aid providers are becoming increasingly expensive with every passing year, which can be a reason why customers have high expectations as they consider medical aid providers to be relatively expensive. According to Brand-Jonker (2019b), six medical aid providers have already announced contribution increases and four of these medical aid providers (i.e. Bonitas, Discovery, Fedhealth, and Momentum Health) are part of the five major open medical aid providers as indicated in Table 1-2.

It is important that medical aid providers should meet current customers' expectations, as competition is intensifying in the medical aid industry, allowing customers to choose between various medical aid options (Selfmed Medical Scheme, 2017).

1.3.2 The South African medical aid industry

A medical aid provider is defined as a non-profit organisation, consisting of a board of trustees (Discovery, 2019b), that aims to assist customers in paying for their healthcare needs, such as hospital accommodation, nursing, surgery, dentistry, and medicine, in exchange for monthly contributions (Erasmus, 2016b; Medical Aid, 2018).

The South African Medical Scheme Act (131 of 1998) states that the 'business' of a medical aid provider is to accept the responsibility to create provision for the attaining of pertinent medical service, to assist in covering expenses suffered in connection with the execution of any relevant medical service, and where applicable, to reduce a relevant medical service, either by the medical aid scheme itself or by any supplier or group of suppliers of a relevant medical service or by any person, in association with, or in terms of an agreement with a medical aid provider, in exchange for a monthly premium or contribution from the customer.

South Africa spends an annual GDP of approximately 8.8% of GDP on healthcare, half of which is spent in the private industry and the other half in the public industry (Groenewald, 2017; Health Policy Project, 2016:1). Medical aid providers are considered to be the main providers of financing for the private healthcare industry and only cover the 16.4% of the population who have medical aid cover (Burger & Christian, 2018:2; BusinessTech, 2019a). Two main types of medical aid options exist in South Africa, namely open medical providers and restricted medical providers (Erasmus, 2016b). The difference between an open and restricted medical aid are discussed in the next section.

1.3.2.1 The open medical aid industry

An open medical aid is available to the public and are open to all customers who wish to become a member, provided that he or she is above the age of 18, able and willing to pay for the membership, and not a current member of any other medical aid (Discovery, 2019b; Erasmus, 2016b; SA Medical Aids, 2017). According to AF Health (2016:9) and Erasmus (2016a), there are 83 registered medical aid providers in South Africa, of which 23 are open (CMS, 2015:136; Erasmus, 2017a; SA Medical Aids, 2017). These open and restricted medical aid providers are indicated in Table 1-1.

A restricted medical aid provider, on the other hand, is only available to customers with certain academic qualifications, who belong to a certain trade union, or serve as employees of a particular industry (Erasmus, 2017b; SA Medical Aids, 2017). The remaining 60 registered medical aid providers are restricted medical aids (CMS, 2015:136; SA Medical Aids, 2017), which are also indicated in Table 1-1.

Table 1-1: Medical aid providers in South Africa

Open medical aid provider	Restricted medical aid provider
Bestmed Medical Scheme	AECI Medical Aid Society
Bonitas Medical Fund	Alliance-Midmed Medical Scheme
Cape Medical Plan	Anglo Medical Scheme
Community Medical aid Scheme (CoMMeD)	Anglovaal Group Medical Scheme
Compare Wellness Medical Scheme	Bankmed
Discovery Health Medical Scheme	Barloworld Medical Scheme
Fedhealth Medical Scheme	BMW Employees Medical Aid Society
Genesis Medical Scheme	BP Medical Aid Society
Horizon Medical Scheme	Building & Construction Industry Medical Aid Fund
Hosmed Medical Aid Scheme	Chartered Accountants Medical Aid Fund (CAMAF)
KeyHealth Medical Aid	De Beers Benefit Society
Liberty Medical Scheme	Engen Medical Benefit Fund
Makoti Medical Scheme	Fishing Industry Medical Scheme (FISH-MED)
Medihelp	Food Workers Medical Benefit Fund
Medimed Medical Scheme	Glencore Medical Scheme
Medshield Medical Scheme	Golden Arrows Employees' Medical Benefit Fund
Momentum health	Government Employees Medical Scheme (GeMS)
Resolution Health Medical Scheme	Grintek Electronics Medical Aid Scheme
Selfmed Medical Scheme	Impala Medical Plan
Sizwe Medical Fund	Imperial Group Medical Scheme
Spectramed	La-health Medical Scheme
Suremed health	Libcare Medical Scheme
Thebemed	lonmin Medical Scheme

Table 1-1: Medical aid providers in South Africa (continued)

Open medical aid provider	Restricted medical aid provider
Topmed Medical Scheme	Malcor Medical Scheme
	Massmart health plan
	MBMED Medical Aid Fund
	Medipos Medical Scheme
	Metropolitan Medical Scheme
	Motohealth Care
	Naspers Medical Fund
	Nedgroup Medical Aid Scheme
	Netcare Medical Scheme
	Old Mutual Staff Medical Aid Fund
	Parmed Medical Aid Scheme
	PG Group Medical Scheme
	Pick n Pay Medical Scheme
	Platinum health
	Profmed
	Quantum Medical Aid Society
	Rand Water Medical Scheme
	Remedi Medical aid Scheme
	Retail Medical Scheme
	Rhodes University Medical Scheme
	SA Breweries Medical Aid Society (SABMAS)
	SABC Medical Scheme
	Samwumed
	Sasolmed
	Sedmed
	Sisonke Health Medical Scheme
	South African Police Service Medical Scheme (POLMED)
Topmed Medical Scheme (continued)	TFG Medical Aid Scheme
	Tiger Brands Medical Scheme
	Transmed Medical Fund
	Tsogo Sun Group Medical Scheme
	Umvuzo Health Medical Scheme

Source: Adopted from the CMS (2015:26-27).

Statistics indicate that 58.9% of the 16% of South Africans who have medical aid are customers of open medical aid providers and the remaining 41.1% are customers of restricted medical aid providers (AF Health, 2016:9; Erasmus, 2016c). Therefore, this study focused on open medical aid providers due to the majority of the South African population belonging to open medical aid providers.

1.3.2.2 Major open medical aid providers in South Africa

Table 1-2 provides the five major open medical aid providers in South Africa, based on their market share, solvency ratio, and global credit rating. The solvency ratio is the ability of the medical aid provider to pay its liabilities (Aziz & Rahman, 2017:86), and is specified by the Medical Schemes Act (131 of 1998) to be above 25% (IFC, 2019b). An executive at Genesis Medical Scheme, states that a high solvency ratio will raise the capacity of the medical aid provider to pay claims of customers (Insurance Chat, 2013); whereas, the global credit rating is defined as a credit risk that occurs when an entity fails to meet its predetermined financial commitments as they arise (GCR, 2011).

Table 1-2: Market share, solvency ratio, and global credit rating of major open medical aid providers

Open medical aid name	Market share	Solvency ratio (benchmark = 25%)	Global credit rating score
Discovery Health	2.7 million members	23.4%	AA+
Bonitas Medical Fund	649 032 members	30.7%	AA-
Momentum Health	257 370 members	25.6%	AA-
Medshield	161 456 members	55.93%	AA-
Fedhealth	72 945 members	37%	AA-

Source: Adopted from BusinessTech (2017c), IFC (2019a), IFC (2019b), Momentum (2017), and Sanlam (2019).

From Table 1-2, it is clear that Discovery Health is the largest open medical aid provider in South Africa (Discovery, 2019a; Erasmus, 2016c). Discovery Health provides customers with comprehensive healthcare benefits, such as chronic disease cover, screening, and prevention benefits to cover tests to identify any signs of serious illness, as well as access to any private hospital on most of their available medical plans (Discovery, 2019c).

Although Discovery has a solvency ratio of 23.4%, which is lower than the recommended 25%, they are still considered financially stable (Discovery Health, 2017:44). The second largest is Bonitas Medical Fund, which has been operating for over 31 years and has 273 285 members (IFC, 2019b; Sanlam, 2019). With a solvency ratio of 30.7%, it can be concluded that Bonitas is stable and in a capable position to meet the needs of their customers (IFC, 2019b; Sanlam, 2019). Momentum Health is placed third, with 257 370 members and a solvency ratio of 28.6%, which make them stable and show that they are capable of paying claims (Momentum, 2017). The fourth-largest and also one of the oldest open medical aid providers (operating since 1968) is Medshield (IFC, 2019a). Their solvency ratio is 55.93%, which is way above the recommended 25%, showing that they are stable and have the ability to pay claims (IFC, 2019a). Even though Fedhealth was ranked last, their solvency ratio remains above the recommended 25%, which proves that they are considered a stable medical aid provider (IFC, 2019b).

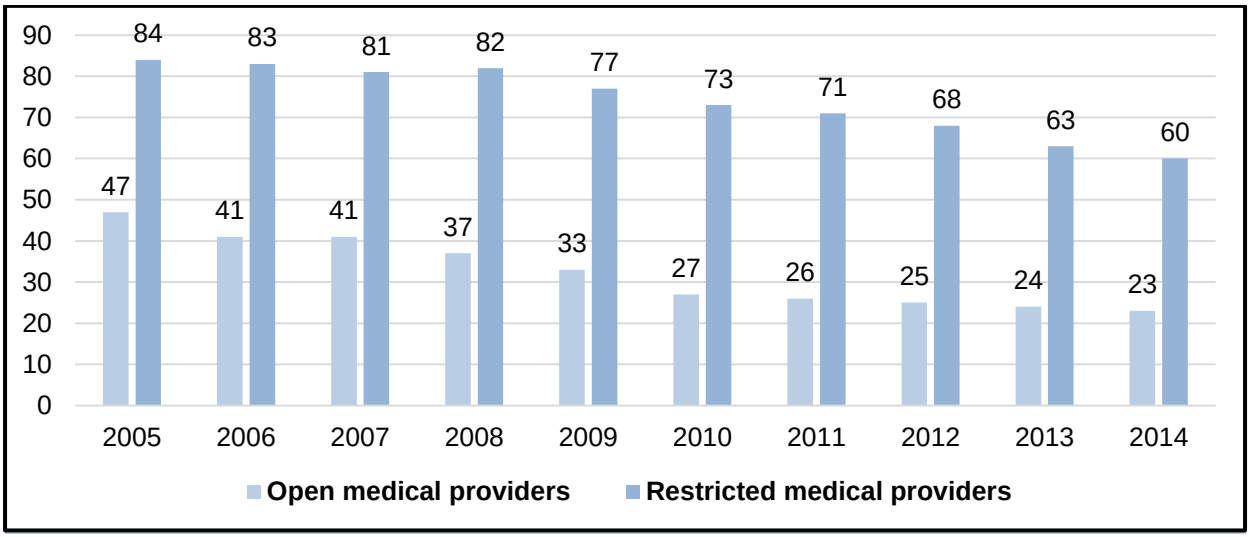
1.3.3 Current trends and challenges in the South African open medical aid industry

South Africa's open medical aid industry is constantly changing (PwC, 2019). At the beginning of 2017, two new regulations were introduced by the National Treasury, which had a significant impact on the South African open medical aid industry. These regulations limit the sum of gap insurance and hospital cash-back policies customers can claim on a daily or monthly basis, followed by the withdrawal of all primary healthcare policies (BusinessTech, 2017b; Makgoo, 2017). Medical aid providers will, therefore, not be allowed to give customers more than R3 000 per day or R20 000 in cashback per month, while the gap coverage will be capped at a limit of R150 000 annually (Makgoo, 2017). However, a massive challenge awaits both open and restricted medical aid providers after the introduction of the National Health Insurance (NHI) Bill during August 2019 (Wasserman, 2019). The NHI is a health funding scheme intended to pool resources to provide all South Africans with access to high-quality accessible private healthcare services depending on their health requirements, regardless of their socio-economic status (CMS, 2019:IX). However, as currently proposed, the NHI Bill contains no clause that compels anyone to be a member of the fund (Cohen, 2019). Medical aid providers may only provide additional cover for facilities that are not reimbursable by the NHI (BusinessTech, 2019c). According to Cohen (2019), the idea is that only major conditions and treatments will be offered by medical aid providers. The open medical aid industry also continues to be transformed by the effects of mergers and amalgamations, accounting standards developments, solvency

measures, advancing technology, enhanced risk management and compliance requirements (PwC, 2019).

Since 2005, the number of open medical aid providers decreased (AF Health, 2016:9). Figure 1-1 provides an illustration of the decrease in open medical aid providers from 2005 to 2014.

Figure 1-1: Decrease in open medical aid providers from 2005 to 2014



Source: Adopted from the CMS (2015:136).

According to CMS (2015:137) and AF Health (2016:9), the decrease in open medical aid providers was mainly due to amalgamation and liquidation. In 2014, amalgamation occurred between two open medical aids (Pharos Medical Plan with Topmed Medical Scheme).

During 2016, amalgamation also occurred when Bonitas Medical Fund decided to merge with Liberty Medical Scheme in order to compete against a hostile economy (AF Health, 2016:9). According to McLeod and Ramjee (2007:56), the non-healthcare costs of open medical aids are relatively high, as they must use brokers to attract new members, which requires additional costs in marketing and acquisition. Therefore, open medical aid providers need to be more careful with contribution increases, as brokers may convince members to leave the particular medical aid provider and change to one that is more affordable (McLeod & Ramjee, 2007:56). More efficient and cost-effective solutions are being prevented due to the lack of engagement by open medical aids with the delivery of healthcare needs, as well as constraints in the provider environment (McLeod & Ramjee, 2007:47).

The survival of non-profit medical aid providers is important as they are considered to be the main providers of insurance for the private healthcare industry in South Africa (Bhana, 2017; McLeod & Ramjee, 2007:47-48). As previously mentioned, medical aid providers are considered to be an expensive service; however, it is a necessity due to the costs of healthcare increasing annually and if customers do not have the right cover or misunderstand the small print (i.e. limits, co-payments, exclusions), they may find themselves in an unexpected health crisis even though they pay for cover every month (Sboros, 2014).

Competition among the open medical aid providers is high as they do not have the guarantee of certain employees, industry organisations or unions to provide them with customers (SA Medical Aids, 2018). It is important for open medical aid providers to build solid relationships with their customers in order to prevent them from leaving and joining another medical aid provider (Qasim & Asadullah, 2012:6). Open medical aid providers can sustain themselves by providing quality medical aid cover that is good and more enhanced than those of other open medical aid providers (SA Medical Aids, 2018). According to Adams (2014), strong customer relationships will enable open medical aid providers to grow without having to take any risks or provide special treatment, which will result in good reputations. Businesses with good reputations will likely be perceived by customers as trustworthy (Keh & Xie, 2009:734). Open medical aid providers can profit from building strong relationships with their customers because it will enable them to distinguish between customers and their needs, as well as alter their products or services according to the needs of their customers (Czarniewski, 2014:88).

1.4 Literature overview

This section provides a literature overview of the discipline (i.e. relationship marketing) and constructs under investigation, including customer engagement, customer satisfaction, trust, affective commitment, perceived value, and service quality. These constructs were selected based on their relevance to the open medical aid industry.

1.4.1 Relationship marketing

Relationship marketing was first introduced and defined by Berry in 1983 (Berry, 2002:59). Since 1983, relationship marketing has been the subject of various investigation papers and the main topic of discussion among academics and research experts (Benouakrim & Kandoussi, 2013:149; Egan, 2011:16). For the past 20 years, several authors have defined

relationship marketing in different ways from various research perspectives, while using Berry's (1983) definition as a basis (Benouakrim & Kandoussi, 2013:149). Some authors considered relationship marketing to be a process (Grönroos, 2004:100; Perrien & Richard, 1995:38), while others described it as a strategic organisation or an organisational value or philosophy (Sin *et al*., 2005:186). More definitions of relationship marketing are provided in Chapter 2.

The term relationship marketing is therefore used for the idea of building and managing relationships with customers (Berndt & Tait, 2013:6). According to Holmlund and Kock (1996:291) and Lan (2015:4), the main emphasis of relationship marketing is on upholding long-term relationships between a business and its customers. Therefore, customer engagement is discussed in the next section.

1.4.2 Customer engagement

Over the years, customer engagement has materialised as a popular topic, with experts showing an increasing interest in the concept of customer engagement (Brodie *et al*., 2011:252; Islam & Rahman, 2016:40; Sashi, 2012:253; Thakur, 2016:152). Even consulting companies such as Nielsen Media Research, the Gallup Group, and IAG Research are also studying the concept of customer engagement (Brodie *et al*., 2011:252). As a result of this interest, a collection of definitions of customer engagement have developed over time, some of which are provided in Chapter 3.

The key for a successful business is to build deeply emotional relationships with customers, because customers who are emotionally engaged tend to spend more money, are less price-sensitive and are more likely to get through a problem than customers who are not as emotionally engaged (Tripathi, 2009:138-139).

According to Dovaliene *et al*. (2015:660), customer engagement is considered a multidimensional construct. Customer engagement can be grouped into three main dimensions (Brodie *et al*., 2011:255; Dovaliene *et al*., 2015:660; Fernandes & Esteves, 2016:127; Javornik & Mandelli, 2012:302), namely:

- Cognitive dimension: A reflection of this dimension includes the level of customer focus on an object, such as the business.
- Emotional dimension: A customer's sense of fitting in with the business.

- Behavioural dimension: This dimension highlights the progressively dynamic part that a customer is taking in the course of consumption.

Roche (2015) and Sashi (2012:258) further elaborate that customer engagement focuses on quality, rather than quantity, and to provide customers with the best possible experience that the business can offer. According to Pansari and Kumar (2016:296), businesses that focus on customer engagement provide customers with more than just a sales pitch, they also provide excellent customer experience and customer support, which can have a positive impact on the business' profits (Cuillierier, 2016:10).

From the research of Sashi (2012:260), So *et al*. (2013:407), Van Doorn *et al*. (2010:256) and Williams (2017:99), various predictors of customer engagement have been acknowledged and are subsequently described (these predictors are discussed in more detail in Chapter 3):

- **Customer** interaction**:** Customer interactions are required to achieve meaningful relationships between businesses and customers (Hudson *et al*., 2015:2). Customer interaction enables customers to add value, as well as collaborate in creating value (Sashi, 2012:262).

- **Brand attachment:** According to Van Doorn *et al*. (2010:256), high and low brand attachment levels can lead to engagement with customers. Park *et al*. (2010:2) define brand attachment as the power of the relationship between the brand with the customer, which also predicts intentions to execute behaviours that use essential customer resources, such as time, money, and reputation.

- **Brand commitment:** Brand commitment is also perceived as a predictor of customer engagement, which results from trust in a brand (Sashi, 2012:263; Van Doorn *et al*., 2010:256). According to Ramirez *et al*. (2017:10), brand commitment is a connection or emotional feeling that customers display towards a certain brand with the anticipation to build a long-term relationship with the brand.

- **Customer commitment:** Commitment is defined by Dwyer *et al*. (1987:19) as an understanding or direct pledge of interactive continuousness between a business and its customers (exchange partners). According to Terblanche (2008:71), commitment will cease to exist if the exchange partners are not of the same opinion regarding the significance of the relationship. Furthermore, Allen and Meyer (1990:1) propose that

customer commitment consists of three types, namely affective, calculative (also known as continuance) and normative commitment. However, according to Gustafsson *et al*. (2005:211), calculative commitment and affective commitment are seen as the two major types of relationship commitment. Calculative commitment, according to Sashi (2012:263), is sensible and results from an absence of choice or changing costs, whereas affective commitment is emotional and results from the confidence and mutual benefit in a customer to business relationship.

- **Customer satisfaction:** According to research done by Dovaliene *et al*. (2015:663) and Mohsan *et al*. (2011:268), customer satisfaction should be treated as a predictor of customer engagement, as it is considered a critical scale used to measure whether customers' requirements are being met or exceeded. Customer satisfaction is also considered a starting point of standardised and excellence of performance for numerous businesses (Sharmin, 2012:17).

- **Customer involvement:** According to Malciute (2013:5), customer involvement is considered to be a valid predictor of overall customer engagement. Customer involvement refers to a customer's state of mind of identification with a product or service (Cheri, 2016:2).

- **Trust:** Trust is considered to be the basic ingredient of a relationship (Sarwar *et al*., 2012:28), which highlights the importance of trust in customer relationships as it can influence customers' decisions, either to pursue or to terminate their relationship with a business (Nguyen *et al*., 2013:96).

- **Perceived value:** According to Floyd *et al*. (2009:186), Kim *et al*. (2013:364), and Thongthip and Jaroenwanit (2016:12), perceived value is considered a predictor of customer engagement as the intention of a customer to carry on engaging with a business can depend on perceived value.

- **Service quality:** Service quality, according to Puriwat and Tripopsakul (2014:42) and Rossman *et al*. (2016:543-544), is a positive predictor of customer engagement due to the significant influence of the service quality factors on customer engagement.

For the purpose of this study, only customer satisfaction, trust, affective commitment, perceived value and service quality were further investigated as possible predictors of

customer engagement, in Chapters 2 and 3. These constructs are selected based on the relevance that it may have within the context of the open medical aid industry.

The results of research conducted by Sorenson and Adkins (2014) indicated that customer engagement could be based on three conditions. Firstly, the business ensures that it fulfils all the promises made. Secondly, customers are proud to be part of the business; and lastly, customers feel that the business and its product or service offerings perfectly satisfy their needs. Therefore, the study also investigated customer satisfaction as it is also considered an important determinant of long-term customer behaviour (Malciute, 2013:5; Mohsan *et al*., 2011:264; Ranaweera & Prabhu, 2003:82).

1.4.3 Customer satisfaction

Customer satisfaction is a popular concept in marketing sciences and it is considered important for business success (Dehghan & Shahin, 2011:3). Oliver (2010:8) defines customer satisfaction as a judgement that the product or service, or feature of the product or service, delivered an enjoyable level of consumption-related fulfilment. Farris *et al*. (2010:58) define customer satisfaction as a marketing phrase that determines how products or services provided by a business meet or exceed a customer's expectations. Customer satisfaction is influenced by two variables, namely service performance expectations and experiences (Dehghan & Shahin, 2011:3). Oliver (1980:461) presents the confirmation/disconfirmation paradigm, which proposes a conscious or unconscious evaluation of the perceived performance of a product or service with the anticipated performance. According to Cadotte *et al*. (1987:305), this paradigm is known as a view of the system by which customers feel happy or dissatisfaction (CS/D).

Even though there are various definitions of customer satisfaction, they all share the following three elements (Giese & Cote, 2000:2; Kanning & Bergmann, 2009:337; Pankaj, 2015):

- It is an emotional or rational response.
- The reaction relates to a specific focus, such as familiarity with perceptions, product, or consumption experience.
- The reaction happens at a certain time, usually after the consumption, after the choice, or based on collected experience.

Customer satisfaction increases customer retention and attracts new customers through positive word-of-mouth communication, which ultimately has a positive influence on the profitability of a business (Singh, 2006:3; Zhang & Pan, 2009:24). It is further regarded as the primary indicator to measure customer loyalty, serves as a key differentiator in a competitive market, and reduces customer churn and negative word-of-mouth (Jamejami, 2016:73-74). The higher the level of satisfaction, the higher the sentimental attachment (Chinomona, 2013:1307) of customers with the particular product or service and with the business will be, which contributes to establishing a strong, healthy customer-business relationship (Helgesen, 2007:819).

Satisfied customers are those whose expectations have been met or exceeded by a business, whereas a dissatisfied customer is a person whose expectations have not been met by the business (Angelova & Zekiri, 2011:236, 238; Layne, 2017). Satisfied customers will promote the business' products or services, as they will want to share their experience and gratitude for being treated well (Hapsari, 2015:121; Seth, 2014:21). No business can survive without customers; therefore, customers must be valued and managed (Adegbola, 2010:1; Gupta & Lehmann, 2003:9). Customers can freely choose which products or services they would like to purchase, and therefore, open medical aid providers should ensure that customers' expectations are being satisfied by offering decent services and good value for money (Adegbola, 2010:1; Kim, 2006:48).

Critical success factors of any business, such as revenue, image, and status, depend on customers; therefore, it is important for all open medical aid providers to meet customers' expectations in order to keep customers satisfied (Adegbola, 2010:1). According to Ilieska (2013:329), customer satisfaction is considered very important for the success and continued sustainability of any business; therefore, if medical aid providers wish to remain financially sound, data regarding customer satisfaction should be constantly gathered and analysed.

1.4.4 Trust

According to Paliszkiewicz and Klepacki (2013:1288), the concept of trust has been examined by various academics (Siau & Shen, 2003:92), which has evidently led to the development of various definitions of trust. However, several academics (Halliburton & Poenaru, 2013:3; Paliszkiewicz & Klepacki, 2013:1288; Siau & Shen, 2003:92; Simpson,

2007:264) agreed that the main goal of customer trust is to aid in the improvement of a relationship between a business and its customers.

According to Siau and Shen (2003:92), trust mainly has three features:

- Two parties are included in a trust relationship, normally the business and customer.
- Trust consists of uncertainty and risk. According to De Janasz *et al*. (2012:35), trust does not exist without some risk, and therefore, the customer who places confidence in the business has no choice but to hope that the business will treat the information that was given in confidence.
- The business has confidence in the customer and relies on the customer, to be honest, and hopes that he/she will not deceive the business' risk-assuming behaviour (Siau & Shen, 2003:92).

When considering the business-to-customer market, it would be beneficial for a business to develop trust for trade purposes (Marakanon & Panjakajornsak, 2017:25). According to Xie and Peng (2009:574), trust is further examined by separating it into three types:

- **Competence-based trust** is the trust customers have in a business to fulfil their promises, whether they g*et al*ong or not (Alleyne, 2013). It is the ability of a business to comprehend promises. This type of trust develops when the business embraces suitable knowledge, skills, expertise, leadership, and other characteristics in related areas.
- **Benevolence-based trust** is trust that the business has good intentions towards customers (Alleyne, 2013). The business has a genuine concern for their customers' well-being and is motivated to provide customers with value.
- **Integrity-based trust** is similar to benevolence trust, the only difference is that integrity is driven by moral character (Alleyne, 2013). The business is devoted to a set of well-established principles (Xie & Peng, 2009:574) and will operate according to their principles (Alleyne, 2013).

According to Harwood *et al*. (2008:109), trust is important in the establishment of service-based interactions. Trust protects customers by helping them to make a decision by reducing the risk or uncertainty that customers may experience in certain situations (Halliburton & Poenaru, 2010:4). By establishing and maintaining positive customer trust,

open medical aid providers should be able to successfully achieve long-term relationships with their customers (Paliszkiewicz & Klepacki, 2013:1288). Without trust, business-customer relationships would be non-existent (Siau & Shen, 2003:92). According to Paliszkiewicz and Klepacki (2013:1288), businesses are becoming more and more focused on the development and improvement of long-term relationships with their customers. Customer trust is considered an important ingredient for developing and improving relationships with customers (Simpson, 2007:264; Singh & Jain, 2015:973). However, in order for a business to achieve successful customer relationships, the existence of both trust and commitment are required (Wang, 2009:863).

1.4.5 Affective commitment

According to Walter *et al*. (2002:8), customer commitment can be defined as customers' intention to continue a long-term relationship with a brand or business due to a feeling of attachment and sincerity (Lacey, 2007:317). According to Pansari and Kumar (2016:296), commitment is the seriousness of the customer's attitude towards the business and its product or service offerings. Commitment is considered the main feature in a relationship that distinguishes a relationship from other forms of business transactions (Harwood *et al*., 2008:110). Commitment symbolises customers' dedication and devotion to a business' products or services (Oba, 2017). Commitment allows customers to devote themselves to a business and its product or service offerings (Keller, 2013:351), regardless of foreseen or unforeseen circumstances. According to Meyer and Herscovitch (2001:301), overall definitions of commitment mention that it is an obliging or stabilising force that provides direction to a customer's behaviour. It is important for any business to understand the complex nature of customer commitment, especially with the continuous increase in customers' bargaining power (Al-Abdi, 2010:9).

Commitment can be categorised into three types, namely affective commitment, continuance commitment, and normative commitment (Meyer & Allen, 1991:67). *Affective commitment* is a customer's emotional attachment, identification, as well as involvement with a business (Anttila, 2014:8; Istikhoroh & Sukamdani, 2017:118) and refers to a desire-based connection (Bansal *et al*., 2004:236). It shows that customers are staying with the business because they want to (Bansal *et al*., 2004:236; Meyer & Allen, 1991:67). Fazal-e-Hasan *et al*. (2017:202) define affective commitment as a customer's yearning to continue a respected relationship with a business. *Continuance commitment* is based on the costs that would arise if a customer decides to leave the business (Anttila, 2014:8; Istikhoroh & Sukamdani,

2017:118). It occurs when customers remain with the business because they feel like they need to (Bansal *et al*., 2004:236). In other words, the cost of leaving the business would be too high, and therefore the customers decide to rather remain with the business (Anttila, 2014:8-9). *Normative commitment* refers to an obligation-based connection of a customer (Bansal *et al*., 2004:236; Istikhoroh & Sukamdani, 2017:118). This component is considered to be the least desirable, as it reflects a customer's feeling of obligation to stay with a business (Meyer & Allen, 1991:67). Normative commitment occurs when customers stay with the business because they feel they have to (Bansal *et al*., 2004:236). According to Istikhoroh and Sukamdani (2017:118) and Vivek *et al*. (2012:135), affective commitment reflects an emotional connection with a business, which encourage customers to stay in a relationship with the business, necause they genuinely want to. Therefore, this study focused on affective commitment, as it is seen as more optimistic and ruled by the free choice of customers (Evanschitzky *et al*., 2006:1207).

1.4.6 Perceived value

According to Zeithaml (1988:3-4), perceived value is not like objective or real value – it is a advanced level perception rather than a particular feature of a product, followed by an overall assessment that resembles attitude and a conclusion. Demirgüneş (2015:212) suggests that perceived value can be defined from various viewpoints (i.e. money, quality, as well as social psychology) and results from an assessment of the comparative prizes and losses related to the offering (Khraim *et al*., 2014:187; Yang & Peterson, 2004:803), which may encourage customers to patronise the business again (Ishaq, 2012:25-26). Sanchez-Fernandez and Iniesta-Bonillo (2007:431-434) and Zauner *et al*. (2015:3-5) propose that the conceptualisation of perceived value can be divided into the following three stages:

1. The unidimensional conceptualisation: This stage focuses on the financial and rational features of perceived value, stating that in order to maximise the significance of decisions, customers behave wisely.

2. The multidimensional conceptualisation: This stage recommends that utilisation choices are influenced by cognitive as well as affective components; therefore, during this stage, the focus is shifted from the economic value to the developing importance of emotions in customer behaviour research.

3. The higher-order conceptualisation: During this stage, the examination moves from understanding and describing, to analysing and applying perceived value in connection to different ideas and everyday circumstances.

Bowman and Ambrosini (2000:2) suggest that customers' perceptions of the significance of a product or service are centred on their views about the product or service, their necessities, sole experiences, requirements, desires as well as their expectations. The actual performance of a product or service in connection to customers' hopes will determine whether they have received the guaranteed value (Lin, 2003:28). By creating and providing decent experiences, businesses can give the value that will rise the purchase intention of customers (Demirgüneş, 2015:221). Therefore, it is undeniable that one of the main tasks for businesses is to provide superior value to customers (Hansen *et al*., 2008:206).

1.4.7 Service quality

According to Suwannapirom and Lertputtarak (2005:128), services are seen as actions, benefits, or fulfilments offered by businesses for a price. Quality has become a major part in everyday life (Mosadeghrad, 2014:77). However, quality can mean different things to different individuals. Some customers consider quality as the skill of a product or service to satisfy a want or need (Janse van Rensburg *et al*., 2008:110).

Hoffman and Bateson (2017:399) define service quality as an attitude, formed by the whole evaluation of a business' performance in the long term. Yarimoglu (2014:80) states that service quality determines how much the service rendered meets or exceeds the customer's anticipations. It affects the repurchase intentions of current as well as prospective customers (Ghobadian *et al*., 1994:44). According to Hoffman and Bateson (2017:400), service quality is a significant element in order for a business to achieve success and ensure survival. The reason for this is that businesses with high quality services usually have a larger market share, advanced ROI (return on investment) and higher asset turnover (Ghobadian *et al*., 1994:43; Hoffman & Bateson, 2017:400).

Zeithaml *et al*. (1996:33) suggest that service quality and behavioural intentions are connected, meaning that service quality is an element of whether a customer will stay with or defect from a business. Therefore, it can be concluded that a significant element influencing business performance in the long term is the quality of services presented by the business (Ghobadian *et al*., 1994:43). According to Wilson *et al*. (2012:83), research suggests that customers judge quality based on several factors related to the situation. Parasuraman *et al*.

(1988:13) developed the SERVQUAL measure, which presents five dimensions to measure service quality (indicated in Table 1-3), namely tangibles, reliability, responsiveness, assurance and empathy.

Table 1-3: The dimensions of service quality

Dimension	Definition	Example
Tangibles	The business' physical resources, tools, and employees.	Call centre facilities.
Reliability	The business displays traits that are consistent according to the customer's view of professionalism.	Maintain accurate records.
Responsiveness	The eagerness of employees to assist customers and give quick service.	Responding as quickly as possible to an email from a customer regarding some specific information about a product or service.
Assurance	The knowledge and ability of employees to encourage trust and confidence.	Business stating that a job or transaction will be finished by the proposed date.
Empathy	The capability of the business to provide caring, individualised attention.	Treat the customer as a person and not as a figure.

Source: Adapted from Baldwin and Sohal (2003:208), Parasuraman *et al*. (1988:23) and Yarimoglu (2014:85).

1.4.8 Relationships between constructs

This section provides a discussion on the relationships between the six constructs of the proposed study by looking at previous research.

1.4.8.1 Customer satisfaction and customer engagement

Customer satisfaction is considered to be the first step in building relationships with customers (Tripathi, 2014:124). According to research conducted by Williams (2017:97), it was found that customer engagement requires customer satisfaction in order to build customer relationships. From a customer's perspective, the business can encourage customer engagement by satisfying customers' needs (Gummerus *et al*., 2012:860).

According to Pansari and Kumar (2016:296), if customers are satisfied with the business' product or service, then it is highly likely that they will come back and purchase the product or service again. Through repurchasing the product or service, customers start to engage more with the business. Customers who make repeat purchases are more engaged (Nolinske, 2019). Kim *et al*. (2013:364) state that overall satisfaction is essential for effective customer engagement as it affects customer consumption activity choices. These

researchers also suggest that satisfaction should be considered as a principle of customer engagement, which resulted in the formulation of the following alternative hypothesis:

H_1: Customer satisfaction has a positive and significant impact on customer engagement.

1.4.8.2 Trust and customer engagement

According to Pansari and Kumar (2016:296), trust is the scope of the customer's attitude towards the business and its product or service offerings. Trust is without a doubt the foundation of effective relationships that can lead to higher business profits (Reina *et al*., 2017:2). Customer trust increases sales, recommendations, and positive word-of-mouth communication (Pansari & Kumar, 2016:296). Therefore, in order for engagement to take place, the business should interact with the customer, establish a relationship, and build trust (Sashi, 2012:259). Pansari and Kumar (2016:300) also state that, in most cases, customer engagement occurs after establishing trust and commitment. Sanders (2012:2) states that trust can be considered as both a by-product and a required prerequisite for engagement.

When taking into account the above information, it can be argued that customer trust results in customer engagement, and therefore the following alternative hypothesis was proposed:

H_2: Customer trust has a positive and significant impact on customer engagement.

1.4.8.3 Affective commitment and customer engagement

Bowden (2009:579) states that affective commitment can inspire customers to stay with the business, create a desire to invest in the business, as well as a tendency to engage with the business. According to Naumann and Bowden (2015:59), the concept of affective commitment is relevant to customer engagement as it builds long-term customer relationships. Research done by Van Tonder and Petzer (2018:9) suggests that affective commitment may have a positive and significant connection with customer engagement. As a result, the following hypothesis was proposed:

H_3: Affective commitment has a positive and significant impact on customer engagement.

1.4.8.4 Perceived value and customer engagement

Research by Floyd *et al*. (2009:186) and Kim *et al*. (2013:364) propose that the intention of a customer to continue engaging with a business may depend on perceived value. In other words, during a trade, what the customer contributes can be perceived as a cost, whereas what is received can be seen as a reward, and this cost or reward perception relates to the collaborative nature of customer engagement (Hollebeek, 2011:557).

The research conducted by Hollebeek (2011:557) and Thongthip and Jaroenwanit (2016:12) claimed that perceived value can, however, be a factor that affects customer engagement. As a result, the following alternative hypothesis was proposed:

H_4: Perceived value has a positive and significant impact on customer engagement.

1.4.8.5 Service quality and customer engagement

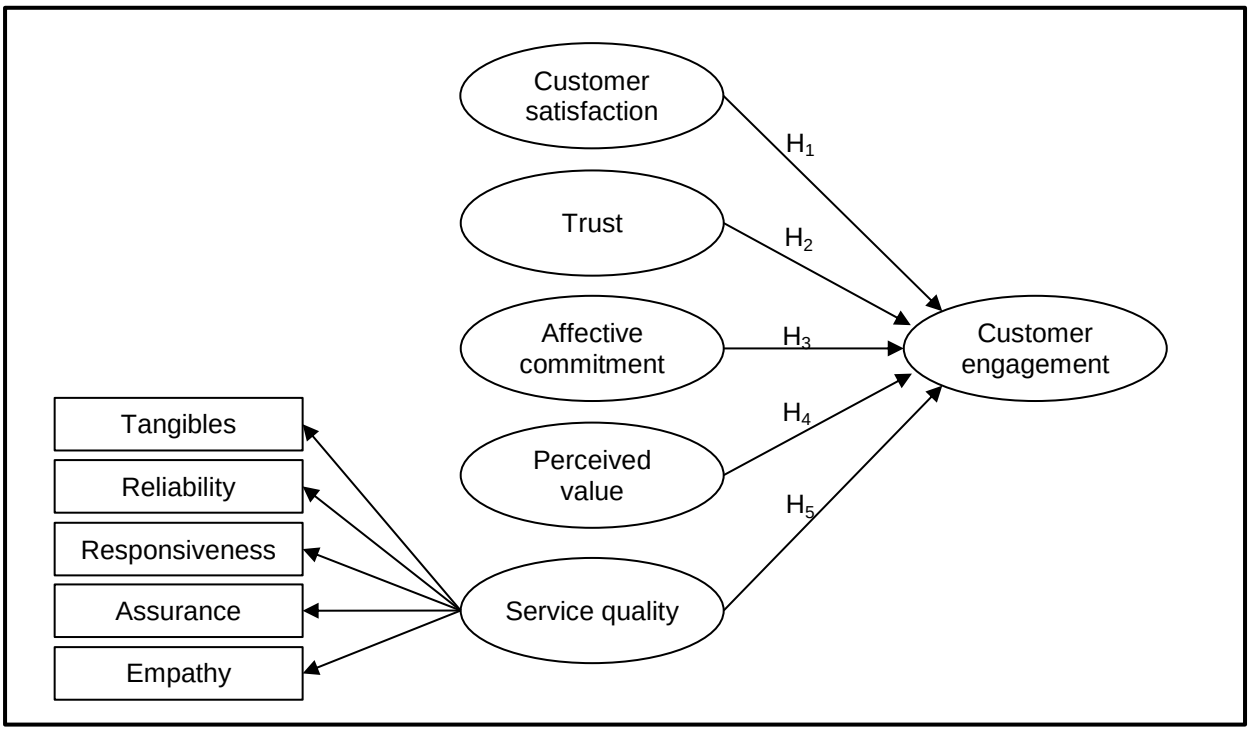
The connection between service quality and customer engagement has only been studied by a few existing empirical studies (Hapsari, 2015:12; Puriwat & Tripopsakul, 2014:42). According to research done by Puriwat and Tripopsakul (2014:42) and Rossmann *et al*. (2016:543-544), service quality has a positive relationship with customer engagement as the predictor element due to the significant impact of service quality factors on customer engagement. Kim *et al*. (2013:364) state that a business' services influence customers' intentions to engage with the business.

Customers consider service quality as an important element when choosing a business and establishing a continuing relationship with that business (Lymperopoulos *et al*., 2006:365). According to Poovalingam and Veerasamy (2007:94), businesses can sustain and improve customer relationships by providing more quality services. As a result, the following alternative hypothesis was proposed:

H_5: Service quality has a positive and significant impact on customer engagement.

Figure 1-2 below illustrates the proposed theoretical framework that has been compiled from the above hypotheses.

Figure 1-2: Proposed theoretical framework



Source: Researcher's own construct.

1.5 Research objectives

The primary objective of this study is to determine the predictors of customer engagement in the South African open medical aid industry. In order to achieve this, the influence of selected relationship marketing constructs (i.e. customer satisfaction, trust, affective commitment, perceived value, and service quality) are investigated.

The secondary objectives formulated to support and achieve the abovementioned primary objective, include:

1. Compile a sample profile of the open medical aid provider customers who participated in this study.
2. Determine respondents' satisfaction with their open medical aid provider.
3. Determine respondents' affective commitment towards their open medical aid provider.
4. Determine respondents' trust in their open medical aid provider.

5. Determine respondents' engagement with their open medical aid provider.

6. Determine respondents' value perceptions of their open medical aid provider.

7. Determine respondents' service quality perceptions of their open medical aid provider.

8. Determine the influence of customer satisfaction, affective commitment, trust, perceived value, and service quality on customer engagement.

1.6 Research methodology

This section provides an outline of the research methodology that was utilized to accumulate and assess the information for the investigation. The research design, population and sampling, measurement instrument, data collection, and data analysis are discussed below, demonstrating the processes that were followed in order to achieve the research objectives.

1.6.1 Literature study

For the purpose of this study, secondary data was gathered from various secondary data sources, such as websites, scholarly journals, theses, and academic textbooks. Different electronic databases, including Emerald Insight Journals, JSTOR, Google Scholar, ProQuest and EBSCOhost were also consulted to acquire existing literature pertaining to relationship marketing, services marketing, customer engagement, customer satisfaction, trust, affective commitment, perceived value, and service quality.

1.6.2 Empirical investigation

In this section, the empirical investigation is discussed according to the research design and method of data collection, sampling, measurement instrument, and data analysis.

1.6.2.1 Research design

The research design is viewed as a master plan that specifies the methods and procedures used to collect and analyse the required data (Burns *et al*., 2017:92). It is important that the research problem and research objectives are clear in order to select a suitable research design (Berndt & Petzer, 2011:31; Burns *et al*., 2017:92). A proper research design will guarantee that the data is gathered accurately within a certain time period, and that the data is accordant with the research objectives (Feinberg *et al*., 2013:54). According to Burns *et al*. (2017:93), there are three types of research designs, namely exploratory research,

descriptive research and causal research. Each of these are discussed in more detail in Chapter 4.

Furthermore, a descriptive research design was deemed most suitable for the purpose of this study, as the study focuses on familiar areas (i.e. customers are unhappy with their medical aid providers) and wishes to describe the characteristics of a certain group of customers, estimate the number of customers who display certain behaviours, or to make customer predictions (Churchill & Iacobucci, 2005:107; Malhotra, 2010:106). The study also has a clear problem statement and hypotheses.

During the research process, data collection can furthermore be classified into two categories, namely qualitative and quantitative research (Burns *et al*., 2017:143). According to Berndt and Petzer (2011:47), quantitative research is generally descriptive in nature and focuses on quantifying the research problem. Quantitative research, also known as survey research, involves conducting a series of standardised questions with predetermined response choices (Burns *et al*., 2017:143). Qualitative research is mostly exploratory in nature and helps the researcher to gain more background information in order to understand the research problem better (Berndt & Petzer, 2011:45). This includes the collection, evaluation, and interpretation of data by looking at what customers say and do (Burns *et al*., 2017:144). For this study, a quantitative research design was followed, as a questionnaire was used to gather the primary data, and quantity is of essence to guarantee that reliable results are obtained to address the primary and secondary objectives of the study.

1.6.2.2 Population

Burns *et al*. (2017:238) define a population as the entire group under study as defined by the research objectives of the study. According to De Vos *et al*. (2011:223), the term population sets limits on a study as it refers to individuals who possess certain characteristics.

For this study, the population included customers who have been the principal or primary members of one of the five major South African open medical aid providers (i.e. Bonitas Medical Fund, Discovery Health, Fedhealth, Medshield, and Momentum Health) for two years or longer in selected cities located in the North West Province (including Potchefstroom, Klerksdorp and Rustenburg). These cities have been selected according to their population size, as Potchefstroom, Klerksdorp and Rustenburg are some of the largest cities in the North West Province (Municipalities of South Africa, 2018).

Because this research aimed to determine predictors of customer engagement in the open medical aid industry in South Africa, it was chosen to define the population in such a manner that prospective participants have been customers of one of the main open medical aid providers in South Africa for at least two years, as they have already had a relationship with the open medical aid provider for some time and may already have engaged with the open medical aid provider (Clifford, 2014).

1.6.2.3 Sampling method

Burns *et al*. (2017:239) define a sample frame as a main source of sample elements (the objects from which the information is desired) in the population. According to Berndt and Petzer (2011:171), it is usually a correct and complete list of the population members for the study that is to be undertaken. Due to the Protection of Personal Information Act (4 of 2013) of South Africa, a sample frame was not publically available for this study.

Two types of sampling methods can be distinguished, namely probability sampling and non-probability sampling (Burns *et al*., 2017:241). According to Kumar (2014:378), probability sampling entails that each individual of the population has a known chance of being included in the sample; whereas, with non-probability sampling, there is no known chance that each individual will be included in the sample (Feinberg *et al*., 2013:304). Probability sampling is based on the idea of random selection and non-probability, on the other hand, is arbitrary and subjective (Berndt & Petzer, 2011:173,175). A more detailed discussion regarding the different types of probability and non-probability sampling procedures are provided in Chapter 4 (see section 4.10.3).

Non-probability, convenience and quota sampling was utilised in this study, as the researcher did not have a sample frame from which the information for the study can be drawn is not available, due to the absence of a sampling frame. Convenience sampling enabled the researcher to conveniently choose potential respondents at several high traffic locations, such as malls and shopping centres in the three selected cities (Mooi *et al*., 2018:46). The population is spread geographically, therefore quota sampling was used to compare the results of the three selected cities in the North West Province (Burns *et al*., 2017:254). Equal quotas of 150 respondents per city was obtained.

1.6.2.4 Sample size

The sample size is generally known as the number of sample elements to be included in a study (Malhotra, 2010:374). According to Berndt and Petzer (2011:176), in order for the sample to be representative, it must be as large as possible. The larger the sample, the greater the accuracy of the information (Burns *et al*., 2017:264).

Table 1-4 provides an indication of sample sizes used in different marketing research studies. These sample sizes have been determined based on experience, which can be used as guidelines, mostly in the case of non-probability sampling techniques (Malhotra, 2010:374).

Table 1-4: Proposed sample sizes for marketing research studies

Type of study	Minimum size	Typical range
Problem-identification research	500	1 000 to 2 500
Problem-solving research	200	300 to 500
Product tests	200	300 to 500
Test-marketing studies	200	300 to 500
TV/radio/print advertising	150	200 to 300

Source: Adopted from Malhotra (2010:375).

Due to the problem-solving nature of this study, the sample consisted of at least 300 respondents (as per the information provided in Table 1-4). However, as mentioned above, quota sampling (with 150 respondents per city) was used to compare the three selected cities, resulting in a sample size of 450. Table 1-5 presents how the quotas were divided for the data collection phase.

Table 1-5: Sampling quotas for the data collection phase

City	Gender	Bonitas	Discovery	Fedhealth	Medshield	Momentum	Total
Klerksdorp	Female	15	15	15	15	15	75
	Male	15	15	15	15	15	75
Potchefstroom	Female	15	15	15	15	15	75
	Male	15	15	15	15	15	75

Table 1-5: Sampling quotas for the data collection phase (continued)

City	Gender	Bonitas	Discovery	Fedhealth	Medshield	Momentum	Total
Rustenburg	Female	15	15	15	15	15	75
	Male	15	15	15	15	15	75
Total		90	90	90	90	90	450

1.6.2.5 Data collection

The survey method used to collect the data was through a structured, self-administered questionnaire. The self-administered questionnaire was used as a measurement instrument to assemble the data from the identified target population. The researcher, who received training in fieldwork and marketing research during her honours degree, and had Marketing Research as a module as part of her honours degree, was responsible for the identification of respondents (by addressing the screening questions, indicated in Appendix A) and collection of questionnaires. The researcher travelled to the selected cities (i.e. Klerksdorp, Potchefstroom and Rustenburg) and handed out the questionnaires at selected high traffic locations. The questionnaires were collected from 27 July 2018 until 9 October 2018. The initial aim was to obtain 300 usable questionnaires and the researcher managed to obtain 307 usable questionnaires.

1.6.3 Measurement instrument

In order to achieve the formulated objectives, a quantitative descriptive research method was used. The questionnaire for this study started with a preamble, explaining the purpose of the study, the rights of respondents, and instructions on how to complete the questionnaire. Thereafter, three screening questions were provided that eliminated those individuals who did not meet the requirements for the study. The questionnaire consisted of the following sections (see Appendix A):

- **Section A:** This section aimed to obtain information in order to set up a sample profile of the respondents (i.e. age, gender, level of education, and employment status), as well as information regarding respondents' medical aid habits. The format of the questions was closed-ended questions with predetermined options.

- **Section B:** This section measured respondents' satisfaction, affective commitment, trust, engagement, value perceptions and service quality perceptions with and towards their open medical aid providers – as adapted from Hellier *et al*. (2003:1798) for customer satisfaction and perceived value, Mosavi and Ghaedi (2012:10094) for trust, Parasuraman *et al*. (1988:38-40) for service quality, Verhoef *et al*. (2002:209) for affective commitment, and Williams (2017:227) for customer engagement – by making use of a five-point Likert scale (where 1 is 'strongly disagree' and 5 is 'strongly agree').

1.6.4 Data analysis

After the data collection process, the data was captured, analysed and interpreted (Zikmund *et al*., 2013:462) by NWU (Potchefstroom Campus) Statistical Consultation Services means of the Statistical Package for Social Sciences (SPSS version 25). A sample profile was compiled by calculating the frequencies and percentages for the variables concerned. Descriptive statistics (means and standard deviations) was also calculated for each construct. A CFA (confirmatory factor analysis) was conducted to confirm the constructs' validity. Furthermore, the reliability of the constructs was evaluated by means of Cronbach's alpha coefficient values. A standard multiple regression was conducted to test the formulated hypotheses. Each independent variable was evaluated in terms of its predictive power, as well as determining the influence of each independent variable on the dependent variable (customer engagement) (Pallant, 2010:149).

1.7 Chapter classification

- Chapter 1: Introduction

  This chapter provides insight into the research topic, as well as the industry overview. The chapter also highlights the structure of the research study indicating the aspects that are further addressed in the study.

- Chapter 2: Services marketing and relationship marketing

  In this chapter, the concepts of services marketing and relationship marketing are discussed from the existing literature. This includes the definition of services, services marketing, relationship marketing, comparison of relationship marketing and transactional marketing, benefits of relationship marketing and the concept of relationship marketing in the open medical aid industry.

- Chapter 3: Relationship quality and customer engagement

  This chapter focuses on investigating the theoretical foundation of customer engagement from a relationship quality perspective. This chapter also provides details of activities that have an influence on customer engagement, namely customer satisfaction, trust, affective commitment, perceived value and service quality.

- Chapter 4: Research methodology

  This chapter provides detail on the methods selected for the data collection and the methodology that was used. Certain aspects of the research methodology that were addressed include the research design, study population and sample size, measurement instrument and the data analysis methods.

- Chapter 5: Empirical results and findings

  In this chapter, an in-depth discussion of the empirical results gained from the collected data are provided. The related data analysis methods are implemented in order to comprehend the objectives and hypotheses for this study.

- Chapter 6: Conclusions, recommendations and limitations

  This chapter contains detail on the recommendations to open medical aid providers based on the results of the study. Furthermore, this section provides a summary of the full study conducted.

1.8 CONCLUSION

This chapter served as an introduction and summary of the study's focus by providing relevant background information to the study, as well as an overview of the South African open medical aid industry. The chapter further presented the research problem, research objectives and the research methodology that was followed. The chapter outline for the study was also presented. Chapter 2 further explores services marketing and relationship marketing.

CHAPTER 2: SERVICES MARKETING AND RELATIONSHIP MARKETING

2.1 Introduction

The aim of this chapter is to provide theoretical insights into the nature of marketing, specifically services marketing, followed by relationship marketing. The chapter started with a discussion of the marketing and how it evolved, followed by defining marketing. A discussion of services and services marketing is provided, followed by the features of services, followed by the classification of services. Furthermore, a discussion of the marketing mix for services is provided, as well as the elements of relationship marketing, which was applied as relevant to the study's industry. This is followed by a discussion of the service-profit chain and lastly, the conclusion.

2.2 Marketing

Even though marketing has evolved over time to become increasingly focused on satisfying customer needs and wants, a lot of customers still have a misperception of what the goal of marketing really is, as these customers believe that marketing is a way of misleading them to make purchases that they do not really want or need (Solomon *et al*., 2009:9; Stoddard, 2016). According to Kerin *et al*. (2013:5) and Stoddard (2016), marketing does involve advertising and/or personal selling, but more specifically, it is a process of developing products to satisfy customers through appropriate pricing, promotion, and distribution. Marketing focuses on attracting customers, convincing them to purchase the product or service, and ensuring that the customers are pleased with their purchase to ensure that these customers will be retained (Mortimer *et al*., 2009:1). Marketing involves a theory, behaviour, a perception, or management strategy that focuses on customers' satisfaction, and comprises actions and procedures to execute this theory (Cant *et al*., 2006:3; McDaniel *et al*., 2013:2). The following section defines marketing.

2.2.1 Defining marketing

Marketing is perceived as a basic, yet important business function that is concerned about the connection between the business and the market in which the business works (Vaaland *et al*., 2008:928). Marketing contributes to achieving the businesses main goals, such as survival, profitability and expansion (Cant *et al*., 2006:1). According to Rahman and Masoom (2012:97), in the 21st century, the main focus of marketing is to build a relationship between a business and its customers. The first and most important principle of marketing is to understand the customer (Mortimer *et al*., 2009:11). Marketing ensures that businesses understand customers' requirements for the purpose of providing products or services that meet or exceed these requirements (CIM, 2015:3; Kotler, 2000:4). According to Cant *et al*. (2006:1), different undertakings such as planning and overseeing product offerings, deciding costs and estimating approaches, creating dispersion methodologies, and communicating with existing and potential customers can be utilized to get to the necessities of current, as well as future customers.

Various definitions of marketing exist (Dibb *et al*., 2012:10). The following are a few definitions of marketing that were adapted from existing literature:

- Kotler (2005:1) defines marketing as a social and managerial process by which individuals acquire what they need or want through creating and trading goods and services with others.

- The Chartered Institute of Marketing (2009:3), views marketing as a management process that is aimed at recognising, anticipating and satisfying customers' needs.

- Solomon *et al*. (2009:34) define marketing as a decision making process in which marketing management determines the strategies that will support the business to attain its long-term aims, followed by the execution of those strategies through the use of available resources.

- Armstrong *et al*. (2012:9) refer to marketing as a social and managerial process by which people and businesses achieve what they want and need by means of building and trading value.

- According to Dibb *et al*. (2012:8), marketing includes individual and business operations, which simplify and speed up rewarding give-and-take interactions in an active setting by establishing, allocating, promoting and rating products, services or philosophies.

- Cant and Van Heerden (2013:22) consider marketing as a combination of management duties and decisions directed towards meeting opportunities and pressures in a dynamic setting so that it's market offering will satisfy customers' requirements and achieve the goals of all stakeholders.

- Kerin *et al*. (2013:20) refer to marketing as a business role and a set of practices used for building, communicating, and providing value to customers and for handling relationships with customers that benefit both the business and stakeholders.

- Nicolau *et al*. (2014:166) define marketing as an activity relating to the business, which includes the preparation and implementation of the marketing mix for ideas, products and services, in an exchange that not only meets the existing requirements of the customer, but also contributes and creates future requirements that will provide profits.

- Grönroos (2017:218) refers to marketing as a customer focus that infiltrates the functions and processes of a business and is geared toward making promises and fulfilling these promises through value propositions.

From these definitions of marketing, it is clear that various key elements can be distinguished, as presented in Table 2-1.

Table 2-1: Universal elements in marketing

Marketing is	Author(s)
...a management process used to identify and satisfy customers' needs	CIM (2015:3), Kotler (2005:6)
...activities relating to the business aimed at simplifying and expediting satisfying exchange relationships	Dibb *et al*. (2012:8), Nicolau *et al*. (2014:166)
…a business function and a set of processes used to build, communicate, provide value and manage the relationship with customers in ways that benefit both the business and other stakeholders	Armstrong *et al*. (2012:9), Cant and Van Heerden (2013:22), Grönroos (2017:218), Kerin *et al*. (2013:20), Solomon *et al*. (2009:34)

From the above definitions, marketing is summarised and defined for the purpose of this study as follows:

Marketing is a business function and management process that involves developing activities to identify customers' needs and to build, communicate and manage relationships with customers in order to achieve the long-term goals of the business as well as its stakeholders.

2.2.1.1 Marketing as a business function

The marketing function is important in any business, as the victory of a business is determined by the marketing effort (Burnett, 2008:2; Cant & Van Heerden, 2013:2; Tracy, 2014:7). Furthermore, marketing helps businesses to accomplish their long-term goals, and to improve their chances of survival, profitability and growth (Cant & Van Heerden, 2013:2). Marketing, especially in the open medical aid industry, is important as it enable open medical aid providers to establish and maintain contact with customers (Urbonavičius & Dikčius, 2008:41).

According to Burnett (2008:3) and Hellriegel (2012:75), the survival of businesses depend upon delivering successful products and services, which in turn depend on successful marketing. Rai and Choudhury (2014:52) support this notion by stating that the victory or failure of any business competing in a market, depend on the marketing strategy they develop and implement. Dibb *et al*. (2012:16-17) state that marketing helps a business to sell its products and services. It is important for open medical aid providers to be effective with their marketing activities in order to develop their offerings and to make a profit (Cunningham, 2018:3). Profits are needed for economic growth, as businesses use profits to purchase more resources (i.e. raw materials), recruit more personnel, attract more investors, as well as produce the additional products or provide services that in turn lead to more profits (Dibb *et al*., 2012:17). McDaniel *et al*. (2013:3) further explain that marketing is everything that a customer encounters, from advertising, to what they hear, to the customer service that they experience, to the follow-up care.

2.2.1.2 Marketing as an exchange relationship

According to Armstrong *et al*. (2012:11), marketing is what happens when people decide to satisfy or meet their requirements and wishes through exchange relationships. Exchange is seen as the act of gaining a preferred item from someone by proposing something else in

return (Armstrong *et al*., 2015:7). According to Bagozzi (1975:32), marketing exchanges are often indirect and usually involve the participation of two parties, as well as intangible and symbolic features. For an exchange to take place, two or more individuals (i.e. customer and business) must be willing to make a trade, and each individual must have something the other desires (Solomon *et al*., 2009:11; Thompson, 2017). The exchange between a customer (buyer) and a business (seller or marketer) is considered a fundamental concept in marketing (De Meyer-Heydenrych *et al*., 2017:9; Thompson, 2017) – with the main aim of retaining customers and building relationships with them (Armstrong *et al*., 2012:11).

In order for the exchange to occur, the following five conditions must be met (De Meyer-Heydenrych *et al*., 2017:9; Houston & Gassenheimer, 1987:5; Kotler, 2000:6-7; Lamb *et al*., 2015:10; McDaniel *et al*., 2013:4):

(i) At least two parties need to participate.

(ii) Each party must have something that the other party wants or needs.

(iii) Each party must be able to communicate and deliver.

(iv) Each party should be allowed to take or refuse the exchange.

(v) Each party should be willing to interact with the other.

Even if all the above mentioned conditions exist, the exchange may still not necessarily take place. These conditions, however, are required for the exchange to be possible. In order for the exchange to be completed successfully, each party must be able to make the offering accessible (Houston & Gassenheimer, 1987:5; Lamb *et al*., 2015:10).

In order to comprehensively understand services marketing, it is important to gain an understanding of what services are. This is discussed in more detail in the following section.

2.3 Services and services marketing

Over the past few years, marketing has endured intense changes (OECD, 2010:16). Due to these significant changes, businesses are required to adapt and develop new services that will meet customers' expectations and preferences (Danciu, 2013:49).

Traditionally, services have been difficult to explain, and the way in which services are produced and provided to customers is often hard to understand, since several inputs and

outputs are both tangible and intangible (Lovelock *et al*., 2004:4; Marić *et al*., 2016:9). Thus, services marketing requires more diverse techniques than the marketing of products (Rust *et al*., 1996:xv).

According to research conducted by Williams (2017:23), it was found that in order to understand the marketing of services better, services and services marketing need to be defined. The following are a few definitions of services that have been formulated over the years:

- According to Rathmell (1966:34), services are acts or processes that cannot be stored like products and are produced as they are consumed.
- Quinn and Gagnon (1986:96) define services as all those economic activities in which the main output is neither a product nor construction.
- According to Grönroos (1990:3), a service is a sequence of activities of a less intangible nature that usually arises in encounters between the service provider's customer and service employees or systems that are offered as solutions to customer problems.
- Gadrey (2000:370) considers a service to be a product which deceases on the spot of its production.
- Lovelock *et al*. (2004:4) describe services as intangible financial activities generating value and offering advantages to customers at precise locations and times as a consequence of the required change in or on behalf of the service recipient.
- Adeyoyin (2005:494) defines services as those distinguishable, fundamentally intangible activities that offer want-satisfaction, and that is not necessarily linked to the purchase of a product nor service.
- Kayastha (2011:316) considers services as something that is neither solid nor liquid or as something that cannot be dropped.
- According to Solomon (2011:326), services are acts or performances exchanged from a business (producer) to a customer (user) without ownership rights.
- Chitty *et al*. (2012:5) define services as an extensive and diverse series of activities that are intangible and often challenging for customers to assess.

- De Vries *et al*. (2012:13) refer to services as intangible activities that expire rapidly and which, in the course of interactive consumption, fulfil customers' direct needs and not the desire for ownership.

- Lamb *et al*. (2015:526) define services as acts, processes and performances.

- Hoffman and Bateson (2017:5) refer to services as actions, efforts or performances.

From the above definitions, services can be defined as intangible, perishable and distinguishable economic activities, acts and performances that are offered to customers at the right time and at the right place without the transportation of ownership.

According to research conducted by Breivik (1995:1), services marketing is an important research area within the marketing discipline. Yet, no universal definition of services marketing has been formulated (Gummesson, 2007:4). The following are two definitions of services marketing have been adapted:

- Lovelock and Wirtz (2011:601) define services marketing as the part of the complete service system where the business interacts with its customers, from publicity to billing.

- According to De Vries *et al*. (2012:42), services marketing is defined as an area of marketing in which the intangibility of products, as well as the problems resulting from this, are crucial.

For the purpose of this study, the definitions of services marketing have been combined to formulate a definition of services marketing for this study. Resulting from the definitions of services and services marketing, services marketing is subsequently defined for this study as follows:

Services marketing can be defined as an area of marketing and the part of the complete service system that consists of intangible, perishable and distinguishable economic activities, acts and performances which are offered to customers at the right time and in the right place during interaction with the service business.

The following section provides a discussion regarding the features of services.

2.3.1 Features of services

Solomon *et al*. (2011:330) state that most products are a combination of products and services. There are four features that differentiate services from products, namely intangibility, inseparability, heterogeneity (also known as variability) and perishability (Cant & Van Heerden, 2015:337; Cunningham, 2018:205; McDaniel *et al*., 2013:418). According to Bateson and Hoffman (2011:57), the intangibility feature is the main source from which the other three features (i.e. inseparability, heterogeneity and perishability) develop. However, research done by Boone and Kurtz (2014:489) and Boshoff (2014:9) identified the fifth feature of services, namely lack of ownership. These features are subsequently discussed.

- Intangibility

The basic difference between products and services is that services are intangible performances, which means customers cannot touch, see, feel or hear services (Cunningham, 2018:205; McDaniel *et al*., 2013:418). According to Wilson *et al*. (2012:16), this feature presents many challenges, as services cannot be licensed easily and new service models would thus be easily copied by contenders. Services are temporary performances that can only be experienced as they are provided (Rust *et al*., 1996:7). This makes it challenging and risky for customers when deciding whether to purchase the service or not (Strydom, 2011:203). In other words, customers look for supportive signs, which is why businesses must ensure that these signs are freely presented (Solomon *et al*., 2009:327). Businesses can encourage these signs by helping customers to assess and compare services by making the services tangible, for instance, more noticeable, or demonstrate why it can be beneficial for customers to use the service (Kerin *et al*., 2013:297).

- Inseparability

In most cases, the customer fails to separate the provider of the service from the service itself (Kerin *et al*., 2013:298). According to Cunningham (2018:207), service production and consumption are inseparable, which implies that a service is delivered and consumed at the exact same time. Even though a business can produce products prior to sale, a service can only take place at the time the service provider carries out an act on either the customer or the customer's possession (Baines *et al*., 2017:572; Solomon *et al*., 2009:328).

Most services have high customer involvement, which makes it difficult to maintain standardisation and control (Dibb *et al*., 2012:383). Thus, whenever a mistake is made or an error occurs, the customer is instantly aware of it and experiences it as it happens (Strydom, 2011:203). According to Hoffman and Bateson (2017:72), service businesses can avoid marketing challenges and errors by implementing the following strategies:

- Increase the importance placed on the selection and training of public contact employees to ensure that the right employees are in the right professions.
- Implement management strategies that facilitate positive service encounters for all customers that share similar service experience.
- Counterbalance mass production encounters by using multisite locations.

♦ Heterogeneity

Heterogeneity, also known as variability, refers to the indication that services vary from one encounter to the next (Armstrong *et al*., 2012:251). According to Wilson *et al*. (2012:16), each customer will have unique requirements and will experience the service in a different way, therefore no two customers will ever experience the service in exactly the same way. Furthermore, human beings are involved in the delivery of a service, which can lead to inevitable variations in the service that is delivered to customers (Strydom, 2011:203). Therefore, it is important for service marketers to develop standards of quality, employ the right employees, provide sufficient training, as well as receive continuous feedback to ensure that customers are not disappointed (Cunningham, 2018:207).

According to McDaniel *et al*. (2013:419), services are more heterogeneous than products, therefore they tend to be less consistent and unchanging. However, customers, in some cases, do not necessarily want consistency, but rather quality when they purchase a service (Solomon *et al*., 2009:328). Therefore, service businesses can implement total quality management which focuses on the devotion of employees and on providing customers with the best possible experiences and possible outcomes (Boljević, 2007:225-226; HEN, 2003:8).

♦ Perishability

Perishability is the fourth feature of services, and refers to the idea that services cannot be stored, warehoused or inventoried like products (Cunningham, 2018:206; McDaniel *et al*.,

2013:419). In other words, it means that a service cannot be produced a month or a week in advance and stored until it is required (Strydom, 2011:203). Normally, the customer of a service has to be present and directly involved in the consumption of the service while it is being delivered (Dibb *et al*., 2012:384). Strydom (2011:203) states that the service has to be produced and consumed when required. According to Moeller (2010:365) and Rust *et al*. (1996:10), the perishability feature burdens service businesses more frequently than product businesses to manage demand, because product businesses can build up inventories to meet peak demand or reduce their prices to move unsold products. Fortunately, service businesses can overcome this burden by employing more personnel and increase their financing and facilities for the purpose of servicing more customers or serving the same number of customers faster, better and at a lower cost (Baines *et al*., 2017:571; HEN, 2003:7).

- Lack of ownership

The final feature of services indicates that the purchase of a service does not result in ownership of anything, and stems from all four of the abovementioned features (Cunningham, 2018:207). Lancaster and Massingham (2011:504) state that even though all the features of services are important, both the intangibility and lack of ownership feature can be classified as the main features of services. According to Strydom (2011:203), customers have no claim to ownership, they merely purchase the right to access or use the service temporarily. Thus, customers simply purchase the right to temporarily use the service (Cant & Van Heerden, 2013:489; Strydom, 2011:203).

After differentiating services from products, it is also important to understand how services can be classified, which is discussed in the following section.

2.3.2 Classification of services

Services are a classified group of deeds, processes and/or performances, therefore, it is highly likely that a business may provide more than one kind of service (Dibb *et al*., 2012:386; Lehtinen & Järvinen, 2015:170). Adeyoyin (2005:497) and Dibb *et al*. (2012:386-387) maintain that services can be meaningfully analysed through the use of a five-category classification. Table 2-2 provides a summary of the classification of services with various service examples. A brief discussion of these classifications follows after the table.

Table 2-2: Classification of services

Category	Examples
Type of market	
Customer	Childcare, legal advice, entertainment
Business	Consulting, caretaking service, installation
The degree of labour intensiveness	
Labour-based	Education, haircuts, dentistry
Equipment based	Telecommunications, fitness centres, public transport

Table 2-3: Classification of services

The degree of customer contact	
High	Healthcare, hotels, air travel
Low	Home deliveries, postal services
The skill of the service provider	
Professional	Legal advice, healthcare, accountancy
Non-professional	Domestic services, dry cleaning, public transport
The goal of the service provider	
Profit	Financial services, insurance, tourism
Non-profit	Some healthcare, education, government

Source: Adopted from Dibb *et al*. (2012:386).

- **Type of market:** According to Dibb *et al*. (2012:386), services are viewed in terms of the type of customer or market they serve. However, this category does not require a detailed discussion as the implications of this distinction are similar to those for all products (Adeyoyin, 2005:497; Dibb *et al.*, 2012:386).

- **The degree of labour intensiveness:** This refers to the ratio of labour costs to capital costs. According to Palmer (2011:19), several services consist of very labour-intensive production methods. Services such as medical care or education require human labour, whereas other services such as telecommunications or fitness centres require equipment (Dibb *et al*., 2012:387). Labour-based services are more vulnerable to heterogeneity, therefore medical aid providers must recognise that their employees are often viewed as the service itself (Adeyoyin, 2005:497; Dibb *et al*., 2012:387).

- **The degree of customer contact:** Two types of customer contact services exist, namely high-contact service and low-contact service (Adeyoyin, 2005:498; Ling-Yee Li *et al*.,

2017:322; Palmer, 2011:18). With high-contact services, customers have a close relationship with the service, as well as the way in which the service is used, while low-contact services entail few concerns for a customer's emotional well-being (Palmer, 2011:18). High-contact service involves healthcare, hotels, real-estate agents as well as restaurants, whereas low-contact services include home deliveries, theatres, spectator sports and dry cleaning (Dibb *et al*., 2012:387). Medical services are considered a high-contact service, therefore it usually involves activities that are directed towards customers, and because this service is directed at customers, the customer must be present during production (Adeyoyin, 2005:498; Dibb *et al*., 2012:387).

- **The skill of the service provider:** The fourth way to classify services is the skill of the service provider (Dibb *et al*., 2012:387). According to Adeyoyin (2005:498), professional services are usually more difficult and highly controlled than non-professional services. In most cases, customers have no idea what the actual service involves or what the cost of the service will be until it has been performed (Dibb *et al*., 2012:387).

- **The goal of the service provider:** In this category, services can be classified according to whether they are profit or non-profit in nature (Dibb *et al*., 2012:387). Medical aid providers, by law, are non-profit trusts, owned by their members (BusinessTech, 2016b). Most non-profit businesses offer services rather than products (Adeyoyin, 2005:498; Dibb *et al*., 2012:387).

The following section discusses the difference between goods marketing and services marketing.

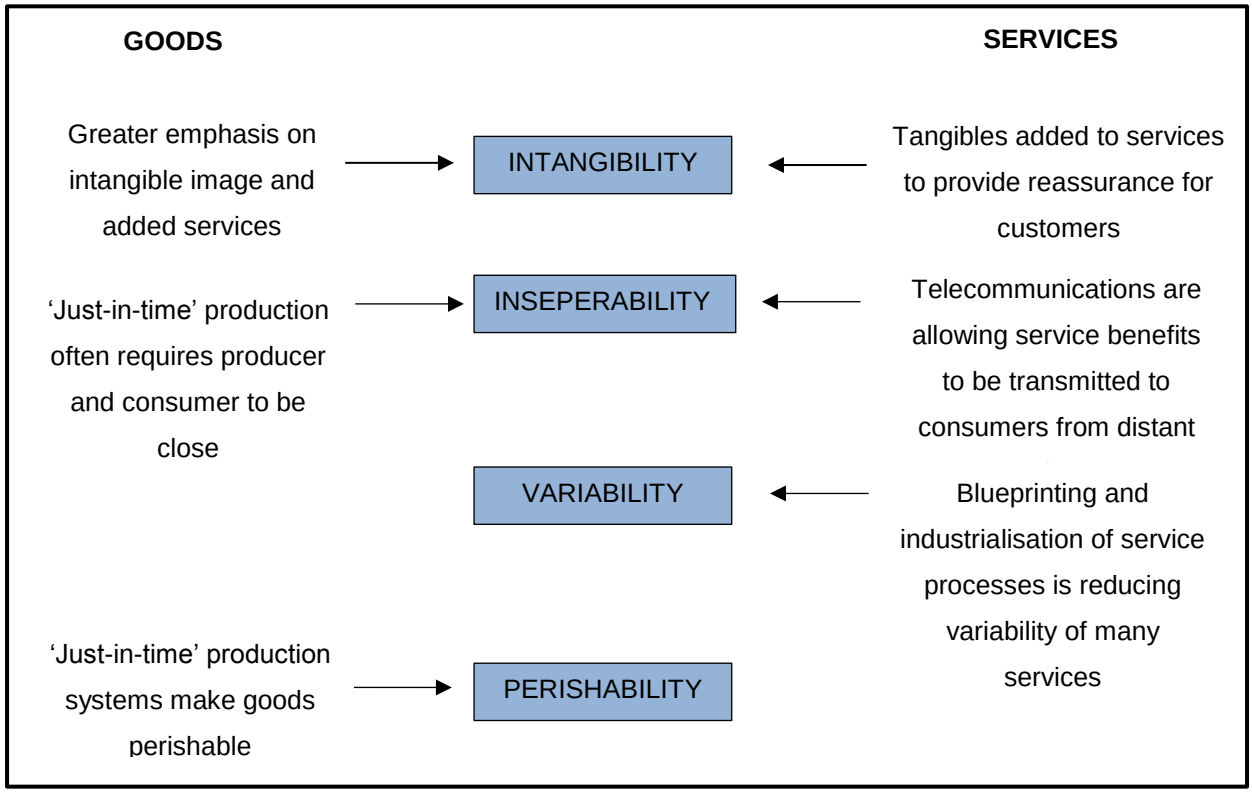
2.3.3 Goods marketing versus services marketing

Marketing originally developed in connection with the selling of packaged goods (Gorchels, 1995:495). Until recently, the marketing of services was understood to be similar to the marketing of goods with the exception that the product was intangible (Fisk *et al*., 2014:8; Hoffman & Bateson, 2017:61). According to Wilson *et al*. (2012:10), marketers moving from marketing in packaged goods sectors to marketing in service sectors found that their expertise and skills were not transferable. Lamb *et al*. (2013:201) support this notion by explaining that businesses experience more difficulty in marketing services than goods. Therefore, an overall agreement exists that services marketing and goods marketing are not similar (Wilson *et al*., 2012:15). Hoffman and Bateson (2017:63) support this notion by

explaining that with services marketing, marketers faced encounters that were not normally faced with the marketing of goods. Differentiating goods from services can be challenging, because when a good is purchased, there is almost constantly a component of service included (Palmer, 2011:30). As shown in

Figure 2-1, services marketing is much more complex than goods marketing, as it involves selecting customers, planning the product, bringing the two (customer and product) together, as well as what happens during the interaction period (De Vries *et al*., 2012:19). Correspondingly, the tangible product attached to the service often amplifies a service (Palmer, 2011:30).

Figure 2-1: Convergence of the marketing of goods and services



Source: Adopted from Palmer (2011:31).

Services marketing obliges marketers to maintain a closer relationship between the business and its customers than is expected in goods marketing (Chitty *et al*., 2012:23; Hoffman & Bateson, 2017:52). According to Chitty *et al*. (2012:23), the marketing strategies used to maintain these relationships involve the 7Ps of the marketing mix, which are discussed in the following section.

2.3.4 Marketing mix for services

According to Cunningham (2018:7), the marketing mix is a well-known term and originally consisted out of 4Ps, namely product, price, place and promotion (Solomon *et al*., 2011:36). However, the 4Ps needed to be adjusted as it was not sufficient for developing a service marketing strategy due to the distinctive nature and features of services (Cunningham, 2018:7, 208). Therefore, in order to meet the requests created by the features of a service, the elements of the marketing mix were expanded by adding three Ps, namely people, processes and physical evidence, to the initial 4Ps, which is now known as the 7Ps in marketing (Cunningham, 2018:7, 208; Lamb *et al*., 2015:529; Tracy, 2014:36). According to Fisk *et al*. (2014:23), these three Ps capture the nature of services marketing and reveal the exclusive character of services (as compared to physical products). Table 2-4 provides a summary of the 7Ps, with examples.

Table 2-4: Summary of the 7Ps

Marketing mix element	Definition	Application to a hotel visit
Product	A product or service offering made by a business.	Different rooms, such as basic or deluxe rooms presented to customers.
Price	The amount paid by the customer to obtain the business' offering.	Different rooms have different prices, which mean that the basic room will be more affordable than the deluxe room.
Promotion	All the elements included in the communication mix that are used to notify customers about the product or service.	Different forms of communication can be used to communicate the offering to customers (e.g. websites, radio or social media).
Place	Refers to where the customer can buy the product or service.	The hotel can be placed close to an airport.
People	The individuals who are involved in the delivery of a service.	Customers must receive consistent service.
Process	The service follows a specific process, from commencing the service delivery, up to the conclusion of the service delivery.	The customer books a room (online or in-person), by selecting a room, booking the room, pays for the room, arrive at the hotel, check-in, go to the room, and check out.
Physical evidence	The physical building where the service is provided.	Hotel chains ensure that their hotels all have the same look, which means the design of all hotels is consistent.

Source: Adopted from Cunningham (2018:7-9).

2.3.4.1 Product

The business' product is the initial point of the marketing mix (Tracy, 2014:36). According to Cunningham (2018:209), the product is the primary benefit which the customer pays for and might include a process, as well as some performance by individuals. Dibb *et al*. (2012:645) state that products can be defined in terms of their physical features, whereas services cannot, due to their intangibility (inability to be perceived by the senses or to be stored in advance of consumption). The product, in this study, refers to the services that open medical aid providers offer to their customers and potential customers. According to BusinessTech (2016a), open medical aid providers' services generally include the following:

- **Hospital plans**: Covers hospital services used when admitted, usually includes anaesthetist and surgeon costs.
- **Hospital plans with savings**: These plans are similar to hospital plans, however, they also provide members with a limited savings account for day-to-day use.
- **Hospital plans with day-to-day cover**: These plans are comparable to hospital savings plans, but generally, come with annual daily usage boundaries that fall away and are renewed at the end of each year.
- **GP network plans**: These plans are designed for the first time younger participants entering the market. The prices of these plans differ depending on the salary of these young members.
- **Comprehensive medical aid**: Plans that have unlimited hospital cover and complete day-to-day benefits.

2.3.4.2 Price

Price refers to the cost expense plus the mark-up to cover the expense as well as the projected profit (Adeyoyin, 2005:501). In simple words, price is seen as the amount of money that customers pay for a product or service (Hellriegel *et al*., 2012:77). According to Dibb *et al*. (2012:642), service marketers face more price restrictions from legal and economic forces than product marketers. Businesses should also keep in mind that a product or service is only worth what customers are willing to pay for it (CIM, 2015:6; Londre, 2018:12). According to De Meyer-Heydenrych *et al*. (2017:342), prices or pricing is about the

ability of the service to satisfy the customer's need, and has little to do with the actual value, price or the cost of the pricing of the service. Pricing consists of wholesale, trade and advertising prices, markdowns, trade-in allowances, quantity discounts, terms of credit, transactions and payment periods as well as loan conditions (Londre, 2018:12). Dibb *et al*. (2012:643) state that the price is considered to be the foundation for differentiation in several business markets and can be adapted, but only to the point where businesses are able to remain sustainable. For open medical aid providers to be competitive in a competitive marketplace, they need to offer a price as low as possible, while increasing their productivity (Coculescu *et al*., 2016:51).

2.3.4.3 Place

According to Ehmke *et al*. (2005:3) and Hellriegel *et al*. (2012:78), place refers to the distribution channels used to deliver the business' products or services to its customers. In other words, place is where the product or service is being provided to the customer (Adeyoyin, 2005:501; Cunningham, 2018:211). It is vital to confirm that the product or service is provided in the correct place, at the exact time as well as in the precise amount (Dibb *et al*., 2012:637), while keeping the packaging, inventory and delivery expenses as low as possible (CIM, 2015:6). In the marketing of products, place refers to the shop at which the customer can buy the product; whereas, in the marketing of services, place refers to the location, which depends on factors such as convenience and popularity of the location and customers' requirements (Cunningham, 2018:211). Customers must be able to access open medical aid providers without experiencing any difficulty (Sreenivas *et al*., 2013:4369). In other words, open medical aid providers should ensure that there are enough outlets available and that these outlets have convenient operating hours (Lamb *et al*., 2013:201).

2.3.4.4 Promotion

Tracy (2014:36) describes the promotion element as an umbrella term that explains everything a business is going to do to notify current and potential customers about the business' products or services and convinces customers to purchase these products or services. According to Ehmke *et al*. (2005:4) and Hellriegel *et al*. (2012:79), the promotional aim is to educate customers about the product or service in order to comprehend what the product or service is, what it can be used for and why it should be purchased. Methods such as advertising, public enlightenment, sponsorship of events can be used to promote a business' services (Adeyoyin, 2005:501; Hellriegel *et al*., 2012:79).

Open medical aid provides can use sales promotion that offers customers incentives such as discounts to lower their monthly contributions or medical costs (Mohammad, 2015:74). According to Cunningham (2018:211), services are difficult to promote due to their complex nature and features, which is why open medical aid providers need to find better and innovative ways to communicate their services in comparison with those of competitors. Lamb *et al*. (2013:201) provide three promotion strategies which open medical aid providers can implement:

- Open medical aid providers can encourage positive word-of-mouth communication among current, as well as future customers by using personal information sources, such as celebrities in their advertisements.

- Open medical aid providers can build a strong business image by managing the physical environment of their facility, the appearance of their personnel, as well as the tangible aspects (bills, business cards and stationery) linked with their service.

- Open medical aid providers can engage in post-purchase communication through follow-up activities, such as telephone calls or postcard surveys to show customers that their feedback is important.

2.3.4.5 People

The people element is the fifth element of the services marketing mix and is regarded as an important element in the services marketing mix (Cant *et al*., 2006:302). Most services demand personal interactions between customers and the employees of a business, and these interactions have a major impact on the perceptions of service quality of customers (Coculescu *et al*., 2016:51; Rust *et al*., 1996:11). The role of personal selling is essential in a variety of business markets, mostly to those in which the purchase is considered risky due to its size, value or complexity (Dibb *et al*., 2012:644). The traditional marketing mix (4Ps) was only concerned with the business and its customers, however, the expanded services marketing mix (7Ps) is concerned with everyone that is part of the manufacture and consumption of a service, whether directly or indirectly (Cant & Van Heerden, 2013:489). According to Londre (2018:9), businesses use customer information and knowledge to better connect with customers and also to develop more appealing business strategies.

The people in open medical aid providers consist of supporting employees and front office executives (Sreenivas *et al*., 2013:4371). According to Mohammad (2015:74), customers

rely on open medical aid providers' employees for advice, complaint and direction concerning some of the open medical aid providers' services and channel of distribution.

2.3.4.6 Processes

The processes element of the service marketing mix refers to how the service is provided (Cunningham, 2018:214). Fisk *et al*. (2014:25) refer to the process as the procedures and flow of activities that contribute to the delivery of the service. Customers are often involved in the production of services, therefore businesses need to consider everything that happens before and after the point when customers buy their products or services (Mortimer *et al*., 2009:18; Rust *et al*., 1996:12). According to Cant and Van Heerden (2013:494), the process is important to ensure well-organised, effective and quality service delivery. It involves the role of open medical aid providers' employees, equipment or machinery, task schedules, procedures, as well as the management of activities (Cunningham, 2018:214; Magrath, 1986:49). In addition, Rust *et al*. (1996:12) and Sreenivas *et al*. (2013:4372-4373) state that the speed of the process and the expertise of the business are both apparent to the customers and important to their satisfaction with the purchase. Creating a good service process will enable open medical aid providers to maintain current customers, as well as attract potential customers (Mohammad, 2015:75).

2.3.4.7 Physical evidence

Physical evidence relates to the setting in which the service is being provided and where the business and customers communicate, as well as any tangibles that could simplify the service's efficiency or communication (Lamb *et al*., 2015:579; Nitin *et al*., 2016:21). The physical evidence of open medical aid providers includes the actual building, building exterior, equipment, staff uniforms, signs, flyers, letterheads, website, business cards and billing statements (Cant & Van Heerden, 2013:497; Sreenivas *et al*., 2013:4372). The physical building where the service is being provided is crucial to a business, as it affects the convenience of the service (Magrath, 1986:48; Mohammad, 2015:76). Service providers that offer services need to provide potential customers with an image that communicates what the business represents (Mortimer *et al*., 2009:18).

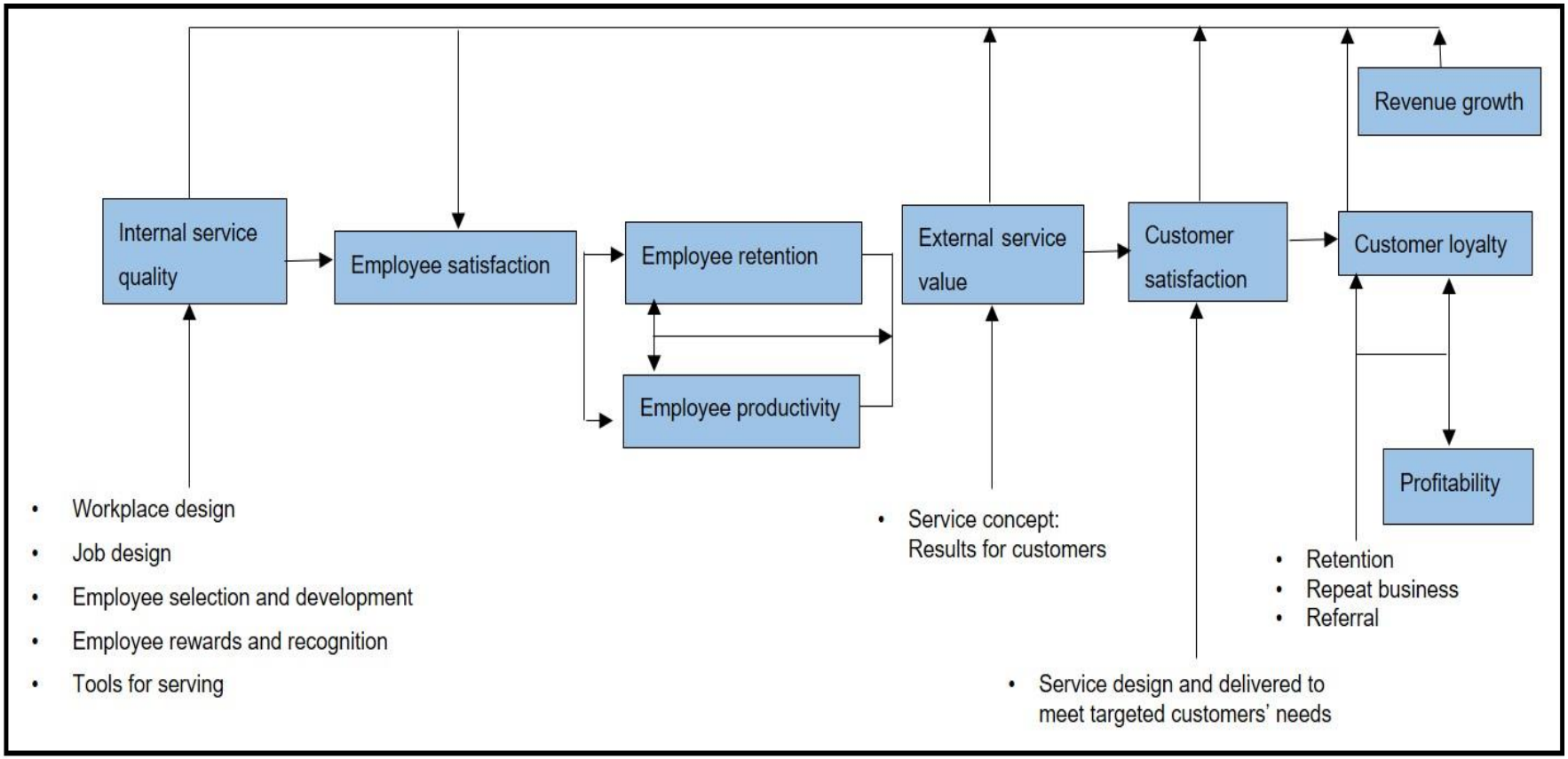
Once a good marketing mix has been established, it is important for a business to remain on top of market changes and to adjust the marketing mix as required (Baines *et al*., 2017:18; Ehmke *et al*., 2005:5). By doing so, businesses can guarantee that quality services are continuously delivered, as service quality is considered a major part of services marketing (Baines *et al*., 2017:579-580; Rust *et al*., 1996:13). Therefore, the service-profit chain is discussed in the next section, as it specifies that there are direct links between a business'

profitability and growth, customer satisfaction and loyalty, the value of goods and services, as well as service quality and productivity (Heskett *et al*., 1994:164; Silvestro & Cross, 2000:244).

2.3.5 The service-profit chain

The service-profit chain, according to Hoffman and Bateson (2017:232), is referred to as the rationality that exhibits the relationship between a satisfied service employee and the profitable performance of the service business. As shown in Figure 2-2, the service-profit chain proposes that there exist precarious links between internal service quality, productivity and satisfaction of employees, the quality of services delivered to customers and finally, customer satisfaction, retention, as well as profits (Ennew, 2015:1; Wilson *et al*., 2012:251). In other words, the service-profit chain describes within a service context, how business performance can be improved by focusing on satisfying customers wants and needs (Ennew, 2015:1).

Figure 2-2: The service-profit chain



Source: Adopted from Heskett *et al*. (1994:166) and Hoffman and Bateson (2017:232).

In addition, the links in the service-profit chain reveal that employee and customer satisfaction are directly related (Hoffman & Bateson, 2017:232). Meaning that if a business can keep its employees happy, they will have a better chance of retaining customers (Lamb *et al*., 2013:204). Heskett *et al*. (1994:165) state that customer satisfaction is mainly influenced by the value of the services delivered. According to Wilson *et al*. (2012:251), the service-profit chain indicates that businesses that show high levels of success on the elements of the chain are likely to be more successful and profitable than other businesses. As a result, customer satisfaction, service quality and perceived value have been selected as constructs for this study, along with affective commitment.

According to Berry (1995:237) and Lamb *et al*. (2013:202), most services consist of constant interactions between the customer and the service business, which facilitates relationship marketing. Therefore, according to Kinard and Capella (2006:360), relationship marketing is connected to services marketing due to the interactions that frequently take place between the customer and the service business. This leads to a discussion of the relationship marketing domain, which is provided in the following section.

2.4 The relationship marketing domain

2.4.1 Defining relationship marketing

According to Rahman and Masoom (2012:97), relationship marketing is an important part of marketing. The following are a few definitions of relationship marketing that have been formulated over the years:

- Berry (1983:25) was the first to present relationship marketing and defined it as attracting, maintaining and improving customer relationships.

- Shani and Chalasani (1992:34) refer to relationship marketing as a combined attempt to recognise, uphold and improve customer interactions, as well as continually reinforce the relationship through interactive, modified and value-added exchanges over a period of time for the mutual gain of both business and customer.

- According to Morgan and Hunt (1994a:34), relationship marketing is all the marketing activities used to focus on creating, developing and preserving successful interactions.

- Palmer (1997:321) interprets relationship marketing from a Japanese outlook as a long-term commitment to customers and suppliers, based on values of total quality management for the purpose of developing customer care.

- Poovalingam and Veerasamy (2007:87) define relationship marketing as the process of establishing and maintaining equally beneficial, relationships between businesses and their customers, personnel, as well as stakeholders.

- Gummesson (2008:5) defines relationship marketing as the interaction in networks of relationships.

- Kibeh (2013:1) refers to relationship marketing as a strategy that is aimed at promoting customer loyalty, interaction and long-term engagement with customers by providing them with information that matches their requirements and interests and by encouraging open communication.

- Boone and Kurtz (2014:346) state that relationship marketing is the development, progress and maintenance of cost-effective, high-value relationships with customers, employees, suppliers as well as other stakeholders (i.e. distributors, retailers) for mutual benefits.

- According to West *et al*. (2015:222), relationship marketing is the development of long-term and intimate relationships between customers and businesses.

According to Krokhina (2017:21), relationship marketing is a management tool used to build and develop long-term relationships between a business and a customer that is beneficial for both sides of the interaction.

It is evident that certain universal elements can be identified from the above definitions. These elements are presented in Table 2-5.

Table 2-5: Universal elements in relationship marketing

Relationship marketing is	Author(s)
...a joint business that contains all the marketing activities.	Morgan and Hunt (1994a:34), Shani and Chalasani (1992:34)
...about recognising relationships with customers and stakeholders.	Boone and Kurtz (2014:346), Shani and Chalasani (1992:34)
...focused on attracting, preserving and improving long-term customer relationships.	Berry (1983:25), Krokhina (2017:21), Poovalingam and Veerasamy (2007:87), Walsh *et al*. (2004:469), West *et al*. (2015:222)
...about constantly strengthening the business-customer relationship by means of customised, interactive, value-added exchanges.	Gummesson (2008:5), Kibeh (2013:1), Morgan and Hunt (1994a:34), Palmer (1997:321), Shani and Chalasani (1992:34)
…mutually beneficial for both the business as well as the customer.	Krokhina (2017:21), Poovalingam and Veerasamy (2007:87), Shani and Chalasani (1992:34)

From the above definitions, relationship marketing is summarised and defined for the purpose of this study as follows:

Relationship marketing is a joint effort from the business that contains all the marketing activities directed toward recognising, attracting, developing, preserving and improving successful long-term relationships with customers and stakeholders, as well as to constantly strengthen this relationship by means of interactive, customised and value-added exchanges for the purpose of achieving mutual benefits for both the business and the customer.

Myftaraj and Nexhipi (2014:1) and Šonková and Grabowska (2015:205) maintain that relationship marketing consists of several activities that businesses can use to attract and retain customers, as well as maintain and develop customer relationships. Customer relationships and the maintenance of relationships between the business and other stakeholders (i.e. suppliers, intermediaries, employees and the public) is the core of relationship marketing (Ravald & Grönroos, 1996:19). Developing these relationships require excellent selling, whilst the maintenance of these relationships require excellent services (Berry, 2002:61). Therefore, it can be concluded that relationship marketing is the key to business success (Rahman & Masoon, 2012:101). However, it is only relevant when there exists a constant desire (from the customer) for the service and when the customer controls the selection of a business and has the option to choose from other alternatives (Berry, 2002:69).

From the literature, a number of characteristics of relationship marketing were identified. A description of each characteristic is provided below.

- **Long-term orientation**

Relationship marketing requires seeking and building long-term customer relationships (McDaniel *et al*., 2013:243). According to Gummesson (2008:20), the main values of relationship marketing can be found in its emphasis on cooperation and the establishment of mutual value. Relationship marketing enables businesses to create customised and personalised communication activities in order to obtain a direct response from the customer whilst sustaining a long-term relationship (De Azevedo & Pomeranz, 2008:5-6).

- **Commitment and fulfilment of promises**

The need to interact in distinct ways depending on the relationship between the customer and the business was recognized by relationship marketing (Egan, 2011:35). Successful relationship marketing requires the presence of commitment and trust (Morgan & Hunt, 1994b:22; Wilson *et al*., 2012:155). According to Aleksejeva (2015:14), the relationship between a business and its customers is considered successful if both parties fulfilled their promises equally.

- **Customer share**

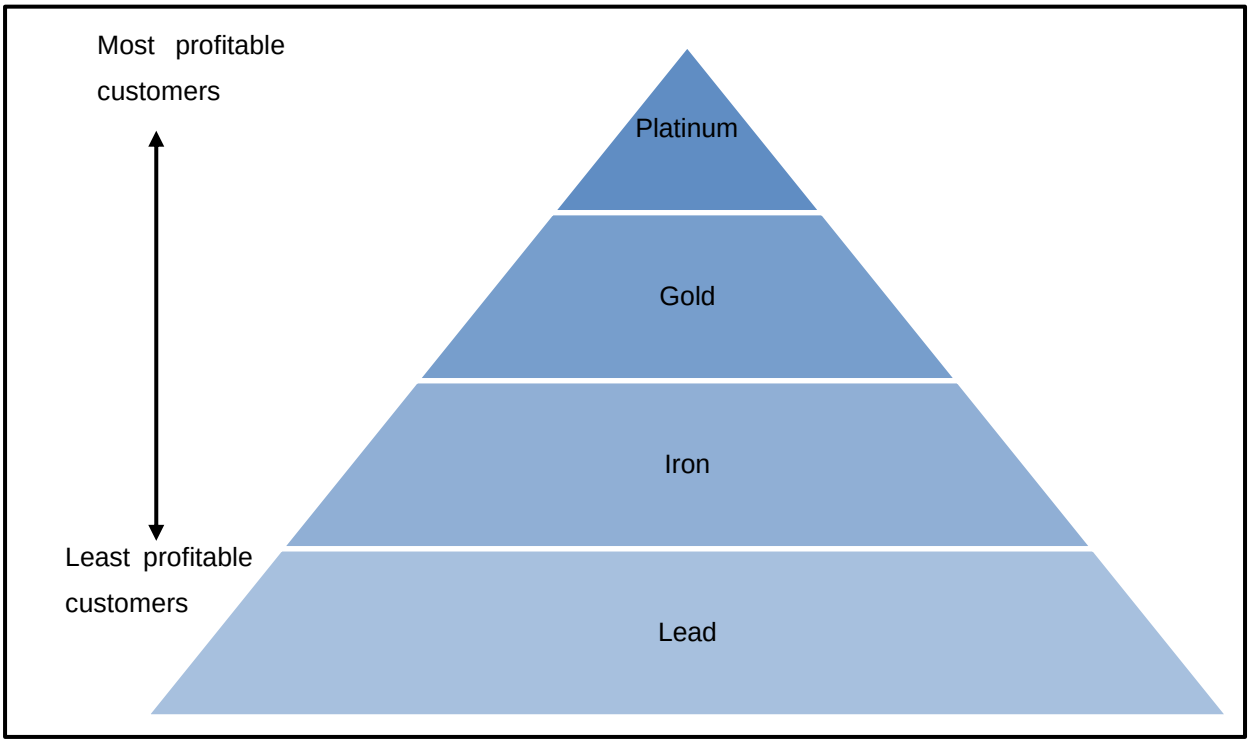
According to Purnasari and Yuliando (2015:150), as the competition in the market becomes more intense, businesses start to realise the importance of retaining valuable customers instead of looking for new customers through long-term relationship maintenance. Relationship marketing shifts the focus of a business from looking for new customers to retaining existing customers (Karimi, 2014:1).

- **Customer lifetime value**

Hult *et al*. (2012:14-15) and Ramachandran (2006:2) define customer lifetime value as a marketing metric projecting a customer's value over the entire history of that customer's business relationship. According to Hosseni and Tarokh (2011:286), customer lifetime value is also recognised as customer equity, customer value and customer profitability. Value from a customer's perspective means high product quality, worthy service and a reasonable price, which is the basis of customer satisfaction (Lamb *et al*., 2015:172).

Zeithaml *et al*. (2001:124) proposed a customer pyramid (shown in Figure 2-3) that categorises customers into a four-segment system based on different projected levels of profit that businesses use to divide customers into four segments, based on profitability. These four segments are explained briefly below.

Figure 2-3: The customer pyramid



Source: Adopted from Berndt and Tait (2012:33) and Wilson *et al*. (2012:150).

These four segments are explained briefly below:

- **Platinum segment**

The platinum segment consists of all customers who fall within the top 25% of the customer lifetime value and are referred to as a business' most profitable customers as they are frequent users of a product or service and not very price sensitive (Pitta *et al*., 2006:426; Schiffman & Kanuk, 2014:12). According to Wilson *et al*. (2012:150) and Zeithaml *et al*. (2001:124), these customers are committed to the business as they are prepared to invest more and try recent developed offerings.

- **Gold segment**

The gold segment has a lower customer lifetime value and varies slightly from the platinum segment with lower but still decent profitability levels as these customers prefer price discounts which limit margins (Pitta *et al*., 2006:426; Wilson *et al*., 2012:150; Zeithaml *et al*., 2001:125). According to Berndt and Tait (2012:33), these customers will still support competitors, therefore they are considered not as loyal as the platinum segment's customers.

- **Iron segment**

According to Pitta *et al*. (2006:426), Wilson *et al*. (2012:150) and Zeithaml *et al*. (2001:125), the spending levels, loyalty and profitability of the iron segment customers are not important enough for special treatment, however, they are considered valuable as they provide the necessary capacity to develop the business' ability.

- **Lead segment**

These customers are considered a risk to a business as they tend to cost more than they generate (Pitta *et al*., 2006:426). Lead segment customers demand more than what they deserve and often complain about the business to others (Wilson *et al*., 2012:150; Zeithaml *et al*., 2001:125).

2.5 Relationship marketing elements

2.5.1 Service quality

According to Parasuraman *et al*. (1985:41), during the 1980s, quality measurement in service was mainly undefined, which resulted in the development of the SERVQUAL model. So far, the SERVQUAL has been identified as the most extensive and effective scale to use when measuring service quality (Amin *et al*., 2013:116; Baines *et al*., 2017:581; Kassim & Abdullah, 2010:353; Ladhari, 2009:1).

At the beginning of its development, the SERVQUAL model consisted out of ten dimensions, namely reliability, responsiveness, competence, access, courtesy, communication, credibility, security, understanding the customer, and tangibles (Daniel & Berinyuy, 2010:10; Parasuraman *et al*., 1985:47). However, later on, these dimensions were reduced to five, namely tangibles, reliability, responsiveness, assurance and empathy due to the overlapping

of some dimensions (Daniel & Berinyuy, 2010:10; Marić *et al*., 2016:13). These dimensions are subsequently discussed in the following sections.

2.5.1.1 Tangibles

The tangibles dimension of a service consists of the physical aspects of the service, such as the physical facility (i.e. where the service is provided), uniforms of employees, tools used to deliver the service, physical representations (i.e. bank statement or credit card), as well as other customers in the service facility (Kabir & Carlsson, 2010:16; Marić *et al*., 2016:13; Parasuraman *et al*., 1985:47).

According to De Jager and Du Plooy (2007:100) and Marić *et al*. (2016:14), customers' perceptions regarding the service quality of open medical aid providers will be influenced by customers' expectations of the physical appearance of the open medical aid provider's building, its neatness and decorations, the professional appearance of employees, and the equipment used to deliver the service.

2.5.1.2 Reliability

The reliability dimension refers to the handling of customers' service complaints, executing services right, as well as delivering the services at the right place, at the exact time (Saghier & Nathan, 2013:4). In other words, here it is determined whether the business kept its promises by providing the service correct the first time (Kabir & Carlsson, 2010:15; Marić *et al*., 2016:13). Lamb *et al*. (2015:241) refer to reliability as a measure of the probability that the service will not fail within a particular time period.

According to Maric *et al*. (2016:13) and Ramsaran-Fowdar (2005:436), customers' reliability of open medical aid providers will depend on the ability of these providers to handle customers' problems or complaints, carrying out the service correct the first time, maintaining accurate records of customers' medical history, and keeping fees and other charges as consistent as possible.

2.5.1.3 Responsiveness

Responsiveness is seen as the eagerness and/or enthusiasm of the business' employees to deliver the service to the customers (Anjum *et al*., 2016:513; Saghier & Nathan, 2013:4). According to Kabir and Carlsson (2010:16), responsiveness involves factors such as mailing a transaction slip, calling customers back in a short time, and providing quick service.

Medical aid providers need to ensure that their employees are able and willing to help customers, provide the service at the time given, avoid long waiting time of customers to receive the service, get an appointment at the time given by the customer, have convenient operating hours, as well as availability at non-peak hours in case of emergencies (Marić *et al*., 2016:13; Ramsaran-Fowdar, 2005 :437).

2.5.1.4 Assurance

According to Anjum *et al*. (2016:512), assurance is mainly the service provider's courtesy, competence and credibility, or in more simple words, the confidence communicated by the service provider and its employees (Boone & Kurtz, 2014:396). Assurance addresses the customer's perceived security and privacy concerns (Kassim & Abdullah, 2010:354).

Customers' perceptions regarding the assurance of open medical aid providers will be mainly influenced by the honesty and friendly support of the provider's employees, their ability to inspire trust and confidence, their ability to handle problems, and to ensure the confidentiality of customers' information (De Jager & Du Plooy, 2007:100; Ramsaran-Fowdar, 2005:437).

2.5.1.5 Empathy

According to Saghier and Nathan (2013:4), the empathy dimension involves employees that recognise the needs of their customers, provide customers with individual attention and convenient operating hours. Empathy shows that the service provider understands customers' needs and that it is willing to satisfy those needs (Boone & Kurtz, 2014:396).

Empathy involves open medical aid providers to listen to their customers, respond to the questions and concerns of customers, understanding customers' requirements, providing personalised attention, and lastly, remembering the names and faces of customers (Marić *et al*., 2016:13; Ramsaran-Fowdar, 2005:438).

According to Leo *et al*. (2005:4) and Rahim *et al*. (2016:247), the behaviour of customers to purchase depends on their perception of the quality of the purchase. Therefore, the perceived value will be discussed in the next section.

2.5.2 Perceived value

According to Dimergüneş (2015:211), perceived value is considered an important element in marketing as it has been acknowledged as a key measure for achieving a competitive lead. Lamb *et al*. (2015:46) note that South African customers are becoming more and more demanding as they insist on high-quality products and services, and no longer accept substandard service delivery or low quality products. Therefore, open medical aid providers need to understand what customers value in order to achieve and sustain a competitive advantage (El-Adly & Eid, 2015:2).

Perceived value, according to Dimergüneş (2015:211), is considered an important element in marketing. According to Sánchez-Fernández and Iniesta-Bonillo (2007:428) marketing literature provides various definitions of perceived value, of which some are presented below:

- Zeithaml (1988:14) defines perceived value as the complete evaluation of the product or service's convenience based on the customer's perception of what was received and what was given.

- Dodds *et al*. (1991:316) refer to perceived value as a rational exchange between perceived quality and the costs involved.

- Yang and Peterson (2004:803) define perceived value as the result of a customer's evaluation of the comparative rewards and sacrifices related to the product or service.

- According to Sánchez *et al*. (2006:397), perceived value is considered an assessment in which customers compare the benefits and expenses.

- Palmer (2009:17) refers to perceived value as the ratio of benefits originating from a product or service to the cost of obtaining the product or service.

- According to Ishaq (2012:27), perceived value is defined as the customer's perception regarding quality, social psychology, benefit, as well as money.

- Armstrong *et al*. (2012:18) define perceived value as an assessment by the customer of the distinction between the advantages and expenses of the product or service offering of a business as compared to the competitors' product or service offering.

- De Meyer-Heydenrych *et al*. (2017:343) define perceived value as the customer's perception of the product or service's worth.

From the different definitions of perceived value, some resemblances can be noted that perceived value is the interpretation of what the customers receive with what they provide (Suryadi *et al*., 2018:3). Chang and Dibb (2012:4) suggest that the personal values of customers can also have an impact on their perceived value of the service or product. Suryadi *et al*. (2018:3) state that what the customers receive can be a service or a benefit, and what they provide is considered a cost or a loss. Businesses can increase perceived value by creating and providing good shopping experiences (Morar, 2013:169). Therefore, marketing research is important as it allows businesses to obtain valuable knowledge about customers' expectations as well as design offerings that meet or preferably exceeds customers' expectations (Strydom, 2011:4). This will lead to customer satisfaction, which is considered an important focus for effective marketing programs and therefore discussed in the next section (Amjadi *et al*., 2016:85; Yang & Peterson, 2004:803).

2.5.3 Customer satisfaction

Customer satisfaction is defined as an individual's overall evaluation of the purchase and consumption experience with a service or good (Anderson *et al*., 1994:54). Andersson and Liedman (2013:1) support this notion by explaining that satisfaction is regarded as a state that customers experience when they are feeling a sense of pleasure and happiness with the delivery of a service. Satisfied customers will likely purchase the product or service more frequently as well as recommend the product or service to others (Khadka & Maharjan, 2017:6). Hong *et al*. (2019:3) note that businesses can identify their position in a competitive market, recognise the factors leading to customer dissatisfaction, as well as introduce countermeasures accordingly by contrasting their level of customer satisfaction with those of other businesses. According to Hoffman and Bateson (2017:368), customer satisfaction has been defined in various ways. Some of these definitions are presented below:

- Oliver (1980:461) defines customer satisfaction as the end result of the change between expected and perceived performance.

- Johnson and Fornell (1991:271) refer to customer satisfaction as a shared denominator on which all consumption experiences can be compared.

- Johnson *et al*. (1995:699) define customer satisfaction as a customer's overall evaluation of the purchase made and consumption experience.

- According to Jamal and Naser (2002:147), customer satisfaction is regarded as a customer's feeling or attitude towards a product or service after using the product or service.

- Angelova and Zekiri (2011:233) indicate that customer satisfaction is the outcome felt by individuals that have experienced a business' performance that have fulfilled their expectations.

- Armstrong *et al*. (2012:584) refer to customer satisfaction as the degree to which a product or service's performance meets the customer's expectations.

- According to Ilieska (2013:329), customer satisfaction is defined as the customers' feelings of happiness or displeasure that result from the comparison of a product or service's perceived performance in relation to their expectations.

- De Meyer-Heydenrych *et al*. (2017:412) define customer satisfaction as the customer's judgement of the product or service in terms of how well its utility met or exceeded the customer's expectations.

- Customer satisfaction is defined by Hoffman and Bateson (2017:368) as the customer's perceptions of the actual service encounter.

- Ranabhat (2018:9) refers to customer satisfaction as a measurement of how well a business' product or service meets the customer's expectations.

- Hong *et al*. (2019:3) indicate that customer satisfaction refers to customer assessment of products or services based on a subjective analysis of product or service performance expected and perceived quality.

Customer satisfaction is considered an important element for every business that wants to increase loyalty, customer retention, as well as product or service repurchases (Khadka & Maharjan, 2017:5,14). Baines *et al*. (2017:593) support this notion by explaining that customer retention and satisfaction are positively related. No business, whether profit or non-profit, can survive in the long-term without satisfying customers' needs (De Meyer-Heydenrych *et al*., 2017:5). Therefore, no business can exist without customers (Hoffman &

Bateson, 2017:287). According to Hanif *et al*. (2010:44), satisfaction occurs when a business fulfils the wants and desires of their customers. Therefore, in order to be sustainable, businesses should meet the needs of customers to be competitive (Nguyen *et al*., 2018:1). Hong *et al*. (2019:2) support this statement by indicating that customer satisfaction is regarded as an important factor in encouraging the selling of products or services and sustainable development of businesses. Customer satisfaction is also considered the condition where the perceived service or quality exceeds the customer's expectation (De Meyer-Heydenrych *et al*., 2017:6; Purnasari & Yuliando, 2015:150). However, customers' expectations constantly change (Andersson & Liedman, 2013:ii), therefore it is important for businesses to provide excellent customer service and service quality in order to be successful in a highly competitive market (Beukes, 2015:1). Pertaining to open medical aid providers, customer satisfaction will help to develop a high willingness among customers to choose the same open medical aid provider repeatedly (Mahadi *et al*., 2017:586).

According to Berry (1995:237), services marketing increases the recognition of possible relationship marketing benefits, as well as challenges for the customer and the business. These benefits and challenges are discussed in the following subsequent sections.

2.5.4 Benefits of relationship marketing

Relationship marketing is beneficial to the business and the customer (Berry, 1995:237). However, there do exist some challenges when it comes to implementing relationship marketing (Heczková & Stoklasa, 2010:86). These sections discuss the benefits of relationship marketing to both the business and the customer.

2.5.4.1 Benefits of relationship marketing to the business

From a business' perspective, developing relationships are crucial to establish a competitive advantage (Hoang, 2015:1). Some of the benefits that could result from these relationships are described below.

- **Competitive advantage**

According to Rahman and Masoom (2012:98), relationship marketing has the ability to form effective relationships with other businesses which could result in a competitive advantage. Relationship marketing enables service providers to be more informed about the wants and needs of the customer (Berry, 1995:238; Ogechukwu, 2012:37), which contributes to a

business' competitiveness by empowering a business to create valuable market offerings more successfully (Aleksejeva, 2015:29).

- **Cost reductions**

Through relationship marketing, businesses can build and develop long-term customer relationships which will enable them to reduce their costs and removal rates (Myftaraj & Nexhipi, 2014:1). Retaining existing customers is much less expensive as opposed to acquiring new customers (Hoang, 2015:5). Existing customers require less attention because they are more familiar with the business (Myftaraj & Nexhipi, 2014:3).

- **Increased customer loyalty**

Relationship marketing aims to create loyal customers because customers who are loyal and have a relationship with a business might ignore competitors' offerings (Magatef & Tomalieh, 2015:78). In other words, the customer becomes loyal, making substantial use of the entire collection of the business' services while overlooking competitors' offerings (Ogechukwu, 2012:31-32). In addition, loyal customers will endorse the business to others via word-of-mouth communication (Ogechukwu, 2012:32; Wilson *et al*., 2012:147).

- **Profit increases**

Loyal customers are less price-sensitive and distinguish a few differences between other offerings, and are therefore considered more profitable (Cant & Van Heerden, 2013:712). The development of relationship marketing enables businesses to keep and develop profitable customer relationships for the purpose of enduring the endless battle for market share (Bazini *et al*., 2012:161). As mentioned, building and developing long-term customer relationships enable businesses to reduce their costs and removal rates, which ultimately leads to more profits (Myftaraj & Nexhipi, 2015:1).

2.5.4.2 Benefits of relationship marketing to the customer

Relationship marketing provides several benefits to customers, namely increased trust, added value, confidence benefits, social benefits as well as superior treatment benefits (Maymand *et al*., 2017:165-166; Nwakanma *et al*., 2007:58-59; Williams, 2017:62). A brief description of each benefit is provided below:

- **Increased trust**

Relationship marketing enable customers to communicate better by receiving applicable information which allows customers, to conduct beneficial purchases (Aleksejeva, 2015:30). According to Myftaraj and Nexhipi (2014:1), customer relationships can be successful depending on the degree of trust between the business and its customers.

- **Added value**

Relationship marketing can also enable customers to experience personalised services that match their requirements, which is important, as customers gain more satisfaction when they buy a service that meets or exceeds their requirements (Aleksejeva, 2015:30).

- **Confidence benefits**

Relationship marketing provides customers with confidence that reduces psychological stress and anxiety when the purchasing decision is made (Al-Hersh *et al*., 2014:76; Taleghani *et al*., 2011:80). According to Gwinner *et al*. (1998:104) and Wilson *et al*. (2012:145), when customers develop a relationship with a business, they begin to experience feelings of comfort or security, because they know what to expect.

- **Social benefits**

These benefits are associated with time, energy and customer efforts (Taleghani *et al*., 2011:80). Customers become more familiar with employees which lead to the development of a friendship with employees (Al-Hersh *et al*., 2014:76). This will prevent customers from switching even if they learn about a competitor that might offer lower prices or provide better quality (Wilson *et al*., 2012:145).

- **Special treatment benefits**

Special treatment benefits include faster service, price breaks as well as individualised additional services (Al-Hersh *et al*., 2014:76; Taleghani *et al*., 2011:81). These benefits, as according to Wilson *et al*. (2012:146) are considered to be the least important of the five benefits of service marketing.

2.5.5 Challenges of relationship marketing

As seen in the previous sections, implementing relationship marketing entails several benefits for both the business and customer. However, implementing relationship marketing also presents certain challenges.

According to Heczková and Stoklasa (2010:86), it is difficult to implement relationship marketing properly and to ensure that it runs efficiently (i.e. employees, technology, investments). By implementing relationship marketing, businesses are challenged to form an perfect system of looking after their customers (Alekseveja, 2015:31). Another challenge of relationship marketing is the safety of information that businesses keep about their customers, sharing this information with a third party and its overall protection, which makes the whole functioning principle of relationship marketing (i.e. collecting data, recording calls, analysing customers' activities) an invasion of customers' confidentiality (Heczková & Stoklasa, 2010:86). Businesses are also challenged to install customer databases, to ensure that these databases are updated regularly and to manage the information collected directly through continuous exchanges between staff at the front-line and customers (Aleksejeva, 2015:32).

2.6 Conclusion

This chapter presented an overview of the distinguishing features of services, as well as the classification of services. Marketing and services were defined, followed by the elements of marketing. In addition, this chapter demonstrated an interest in the academic field on the concept of relationship marketing. A discussion of the theoretical foundation and evolution of relationship marketing and significant research in relationship marketing was summarised. This chapter further revealed the importance of discovering the concept of relationship marketing and continued with a review of several definitions of relationship marketing, declaring how it was defined from this study. The following chapter explains the theoretical foundation of relationship quality and customer engagement.

CHAPTER 3: RELATIONSHIP QUALITY AND CUSTOMER ENGAGEMENT

3.1 Introduction

In the prior chapter, services marketing and relationship marketing were discussed. From this, the theory of the nature of relationship marketing, including definitions formulated over the years and the benefits and challenges of relationship marketing for business, as well as customers, were addressed. This chapter commences with a discussion of the theoretical foundation of relationship quality and customer engagement. This is followed by the significance of exploring relationship quality and customer engagement in order to conceptualise a better understanding of relationship quality and customer engagement. Additionally, the chapter focuses on the importance of customer engagement and continues with a discussion regarding the elements and levels of customer engagement. The chapter ends with a conclusion about the various predictors of customer engagement.

3.2 Relationship quality

The cost of losing customers is very high, especially in a highly competitive market (De Toni *et al*., 2017:123). Hunt *et al*. (2011:82) propose that relationship quality can be positively associated with the level of customer activity in the relationship. Byramjee *et al*. (2010:56) maintain that better relationship quality will maximise the benefits and minimise the costs for both customers and business, which will ultimately maximise the quality for each party. Alawneh (2013:1) supports this notion by explaining that service quality is being substituted by relationship quality as the leading source of superior performance and competitive advantage. Therefore, it is imperative to study and define the concept, which is done in the subsequent section.

3.2.1 Defining relationship quality

Even though relationship quality has been defined in several ways, it is still important to study the concept, as well as to form a proper definition for the purpose of this study. A few definitions of relationship quality are provided below.

- Crosby *et al*. (1990:70) note that, from the customer's viewpoint, relationship quality is accomplished through the salesperson's skill to decrease perceived doubt.

- Moorman *et al*. (1992:316) define relationship quality as the degree to which customers see user-researcher communications as beneficial.

- According to Henning-Thurau and Klee (1997:751), relationship quality as the degree of the fittingness of a relationship to satisfy the requirements of the customer.

- Palmatier *et al*. (2006:138) state that relationship quality is a thorough evaluation of the quality of a relationship, conceptualised as a composite or multidimensional concept, capturing the diverse yet related aspects of a relationship.

- According to Reynolds *et al*. (2014:31), relationship quality alludes to how upbeat or fulfilled accomplices are in a relationship and how well they g*et al*ong.

- Vize *et al*. (2017:2) view relationship quality as the significance of the general valuation of the quality of a relationship between the dealer and the customer.

According to Alawneh (2013:1), relationship quality only focuses on long-term customer relationships rather than on short-term transactions. Extraordinary relationship marketing shows that customers are able to depend on the business' integrity and that the customers display confidence in the business' performance, since the business' previous performance has been consistently satisfactory (Crosby *et al*., 1990:70; Purnasari & Yuliando, 2015:150). Marketing activities are all directed towards establishing, developing, as well as upholding successful exchange relationships (Morgan & Hunt, 1994:22). Such relationships minimise uncertainty and help customers to sustain a good relationship with a business (Alawneh, 2013:2). Furthermore, from the definitions given, it is evident that the quality of the relationship concerns the full assessment of the relationship with a business by a customer.

For the purpose of this study, the following definition of relationship quality is formulated for this study:

Relationship quality is the overall evaluation of the strength of the relationship between customers and their open medical aid providers, which is revealed by the degree of the customer's trust and commitment.

Many factors contribute to the success or failure of relationship quality, and trust and commitment are considered to be the two fundamental factors in this regard (De Ruyter *et al*. 2001:281; Morgan & Hunt, 1994b:22; Mukherjee & Nath, 2007:1192; Wilson, 1995:8). Consequently, trust and commitment are discussed in the following sections as the key dimensions of relationship quality.

3.3 Trust

Trust is considered the original dimension of relationship quality and is established in beliefs about how a partner will act in a relationship (Cullen *et al*., 2000:225). According to Paliszkiewicz and Klepacki (2013:1288), there exist various definitions of trust. Tilborg (2015:1) states that an overview of trust is required to gain a better understanding of the concept of trust. Therefore, for the purpose of this study, it is important to study the definitions of trust (presented below) and to formulate a working definition of trust for this study.

- Moorman *et al*. (1992:315) characterise trust as the customers' readiness to depend on a trade accomplice in whom they have certainty.

- Morgan and Hunt (1994b:23) refer to relationship quality the certainty one party has in a trade partner's unwavering quality and honesty.

- According to Mayer *et al*. (1995:712), trust is defined as a party's willingness to be open to another party's actions based on the presumption that the other party will carry out a specific action that is important to the trustee, regardless of the other party's ability to track or regulate it.

- Garbarino and Johnson (1999:73) define trust as the confidence in the quality and reliability of the services the business provides to the customer.

- Keh and Xie (2009:733) refer to customer trust as the overall view of the customer of the ability, benevolence, and fairness of the supplier.

- Customer trust, according to Myftaraj and Nexhipi (2014:1), is the general expectation or hope that another's word (or actions) will be something one can rely on.

- Rahmani-Nejad *et al*. (2014:263) define trust as a customer's expectation that the service provider will provide the product that meets the needs of the customer.

- Sharma *et al*. (2015:47) state that trust is an evaluation of the exchange partner's integrity, reputation and honesty.

- Trust is defined by Robbins (2016:973) as the confidence in the trustworthiness of another person about a particular issue that occurs under conditions of uncertain results.

Based on the above definitions provided, the following definition of trust has been formulated for the purpose of this study:

Trust can be defined as a customer's (the trustor's) overall belief that the open medical aid provider (the trustee) can be relied upon to execute a particular service according to the customer's needs.

3.3.1.1 Types of trust

Trust is regarded as a multidimensional construct (Aurifeille & Medlin, 2009:9; Roy *et al*., 2011:98). Thus, the three types of trust include competence, benevolence, and integrity-based trust (Clark *et al*., 2010:232; Mayer *et al*., 1995:717; Xie & Peng, 2009:574).

- Competence-based trust

Competence refers to aspects such as skills, abilities and characteristics that enable a person to have influence within a particular domain (Mayer *et al*., 1995:717). According to Čater (2007:374), competence reflects the customer's belief that the business has the necessary skill and knowledge to execute the service successfully and consistently.

Pertaining to open medical aid providers, competence trust would then mean that open medical aid customers believe that their medical aid providers have the ability to provide their services in a correct and proper manner (Albrecht, 2002:322; McKnight & Chervany, 2001:49; Pullon, 2008:142).

- Benevolence-based trust

According to Cullen *et al*. (2000:225), benevolence trust is regarded as subjective or emotional, as it involves one partner's beliefs regarding another's concern about the relationship. Xie and Peng (2009:574) define benevolence trust as the degree to which a business (trustee) is believed to willingly do good to the customer (trustor). To conclude, Ulaga and Eggert (2006:315) support this notion by explaining that benevolence trust symbolises the degree to which one partner is concerned about the other partner's welfare and encouraged to strive for mutual benefits.

- Integrity-based trust

Integrity trust, according to Ulaga and Eggert (2006:315), represents whether the exchange partner's word or written declaration can be depended on. In other words, integrity can be seen as a business' devotion to a set of principles, such as legal and moral responsibilities (Xie & Peng, 2009:574). Correspondingly, integrity refers to customers' perceiving that the business promotes, reveal, as well as follow a set of principles and morals that the customers (trustors) consider suitable (Albrecht, 2002:322). Park *et al*. (2014:297) support this notion by explaining that businesses must live up to these principles and morals in order to gain integrity trust from customers.

3.3.1.2 Benefits of trust within the open medical aid industry

The main benefit of building trust, according to Steyn *et al*. (2008:141), is that it enables businesses to establish strong customer relationships. Trust is extremely important in developing and maintaining relationships, mainly in the service sector due to the intangibility and risk involved in service transactions (Roy *et al*., 2011:98). Persaud and Bonham (2018:26) and Sakallaris *et al*. (2016:54) support this notion by explaining that trust is the foundation on which customer-business relationships are built. According to Rahmani-Nejad *et al*. (2014:263), customers have more confidence in the service or product quality of the business when they trust a business. Persaud and Bonham (2018:26) support this notion by explaining that trust predicts the customer's willingness to disclose private information, comply with procedures, as well as be more involved with the business. Therefore, without trust, it is highly unlikely that customers will disclose any medical information (Rowe & Calnan, 2006:4). Trust, according to Brennan *et al*. (2013:682), is used as a quality indicator for how customers assess the quality of open medical aid providers. Birkhäuer *et al*. (2017:1-2) state that customers who have more trust in their open medical aid providers show more

positive health manners, higher life quality and are more satisfied. According to Legido-Quigley *et al*. (2014:1244), trust becomes important in situations where the customer needs to make a realistic decision, such as which open medical aid provider to choose.

Pertaining to open medical aid providers, it can be concluded that if customers trust that their open medical aid providers will provide the required transactional services, then the chances are highly likely that customers will remain with the open medical aid provider, as well as be more engaged.

3.3.2 Commitment

Commitment occurs after trust (Baines *et al*., 2017:593; Little & Marandi, 2006: 52). Ćulibrk *et al*. (2018:2) and Terblanche (2008:71) state that commitment represents the highest stage of personal connection. It is important that businesses show customers that they are committed while offering the main service value to customers (Davijani *et al*., 2015:114). Therefore, it is important to study the several definitions of commitment (provided below) and to formulate a working definition of commitment for the purpose of this study.

- Porter *et al*. (1973:603) define commitment as the strength of a customer's identification with, as well as participation in a business.

- According to Morgan and Hunt (1994b:23), commitment is seen as the belief of the exchange partner that an ongoing relationship with another is so essential that extreme efforts to maintain the relationship are warranted, in other words, the committed party believes that the relationship is worth working for.

- Garbarino and Johnson (1999:73) refer to commitment as the customer's emotional attachment, devotion, concern for wellbeing, identification, as well as delight in being associated with the business.

- Gounaris (2005:127) defines commitment as the need for continuousness established through the willingness to put effort into a relationship.

- Joseph (2012:123) views commitment as a feeling of attachment with, as well as the intention to ensure the continuity of a relationship with a business.

- According to Rahmani-Nejad *et al*. (2014:264), commitment is considered to be the attitude of a customer towards the act of continuing a business partnership.

Based on the definitions provided, the following definition of commitment have been formulated for the purpose of this study:

Within the South African open medical aid industry, commitment can be defined as the customer's (exchange partner's) feeling of attachment with, as well as the intention to continue an ongoing relationship with the open medical aid provider.

3.3.2.1 Types of commitment

The concept of commitment consists of three types, namely affective, normative and continuance commitment (Jaros, 2007:7; Meyer & Allen, 1991:67). A description of each type is provided below.

- **Affective commitment,** according to Jaros (2007:7) reveals customers' commitment to the business based on emotional connections developed mainly through positive experiences. In other words, affective commitment reflects a customer's emotional attachment, identification, as well as involvement with a business (Meyer *et al*. 2012:226; Miedaner *et al*., 2018:2).

- **Normative commitment** reflects a customer's sense of duty to remain with the business (Meyer *et al*. 2012:226). Therefore, customers feel obligated to remain with a business, because they feel that they have to (Meyer & Allen, 1991:67; Miedaner *et al*., 2018:2; Wang *et al*., 2010:5-6).

- **Continuance commitment** is commitment based on perceived costs associated with leaving the business (Jaros, 2007:7; Meyer *et al*. 2012:226; Miedaner *et al*., 2018:2). In other words, customers remain with a business, because they need to (Meyer & Allen, 1991:67).

For the purpose of this study, the main focus will be on affective commitment, as it reveals that customers remain with a business because they want to (Meyer & Allen, 1991:67). Pertaining to open medical aid providers, affective commitment reveals that customers remain with their current open medical aid provider, because they want to. As a result, the benefits of affective commitment within the open medical aid industry will be discussed in the following section.

3.3.2.2 Benefits of affective commitment within the open medical aid industry

The concept of affective commitment, as according to Kumari and Afroz (2013:27), is comprehensive and reflects an overall affective response to a business as a whole. Mercurio (2015:391) states that affective commitment is regarded as the main principle of organisational commitment. According to Gruen *et al*. (2000:37), affective commitment occurs when customers develop emotional attachments to a business based on their feelings toward the business.

Research conducted by Bowden (2009:579) found that affective commitment could lead to a customer's tendency to engage with a business. Trinchero *et al*. (2014:382) support this notion by explaining that customer engagement is seen as the commitment felt by a customer towards a business. McKay *et al*. (2013:57) suggest that customers who are affectively committed to a business are more likely to engage in behaviours that are beneficial to the business. As a result, customer engagement is discussed in the next section.

3.4 Customer engagement

From the previous sections of this chapter, it is clear that building and maintaining relationships with customers are extremely important for business success, especially during challenging times. According to research conducted by Al-Hersh *et al*. (2014:74), it was found that businesses need to begin concentrating on creating committed customers to build and sustain these significant customer relationships. The following sections define customer engagement, as well as explain the different levels and activities of customer engagement. Lastly, the various predictors and consequences of customer engagement are provided, followed by a conclusion.

3.4.1 Defining customer engagement

During the past decade, the term 'customer engagement' has emerged as a topic of great interest and has been discussed in marketing literature, as well as in the business world, which resulted in a range of definitions (Dwivedi, 2015:100; Palmatier *et al*., 2018:3; Sashi, 2012:253). The following are a few definitions of customer engagement adapted from existing literature.

- Schaufeli *et al*. (2002:74) refer to customer engagement as a confident and satisfying state of mind that is characterised by vigour, dedication and absorption.

- According to Patterson *et al*. (2006:1), customer engagement is the level of the distinct physical, cognitive and mental presences of customers in their relationship with the business.

- Bowden (2009b:65) states that customer engagement is a psychological practice that symbolises the essential processes a business can use to improve loyalty among current and new customers, in order to eventually inspire repeat purchases.

- According to Roberts and Alpert (2010:198), customer engagement consists of all those customers who are loyal to the business and willingly recommends the business' products or services to others.

- Van Doorn *et al*. (2010:253) and Verhoef *et al*. (2010:247) define customer engagement as behavioural manifestations toward the business that goes further than transactions.

- Hollebeek (2011b:565) describes customer engagement as the level of a customer's cognitive, emotional and behavioural investment in a particular product or service interaction.

- According to Gupta (2012:108), customer engagement refers to the engagement of customers with one another or with a business.

- Nammir *et al*. (2012:30) define customer engagement as the level of a customer's presence in the relationship with a service business.

- Sashi (2012:257) states that customer engagement goes beyond awareness, buying, satisfaction, retention and loyalty, which forms an opportunity between the business and the customer.

- According to Vivek *et al*. (2012:133), customer engagement is the intensity of the involvement of a customer's (current or potential customer) in and association with a business' offers or operations that can either be initiated by the business or the customer.

- Greve (2014:203) refers to customer engagement as a psychological process that contributes to loyalty building and is also the behavioural expression of a customer towards a business, beyond buying that is triggered by motivational drives and is characterised by a degree of vigour, dedication, absorption as well as interaction.

- Bansal and Chaudhary (2016:15) refer to customer engagement as an emotional attachment that a customer experience during repeated and ongoing interactions with a business.

- According to Palmatier *et al*. (2018:3), customer engagement is the level of an active relationship that a customer shares with a business.

From these definitions of customer engagement, universal elements have been identified, which are presented in Table 3-1, and are discussed in more detail in section 3.4.3.

Table 3-1: Universal elements of customer engagement

Customer engagement	Author(s)
...is a psychological process.	Bowden (2009b:65), Greve (2014:203)
...is a behavioural manifestation that goes beyond the purchase.	Greve (2014:203), Van Doorn *et al*. (2010:253), Verhoef *et al*. (2010:247)
...leads to the creation of loyalty.	Bowden (2009b:65), Greve (2014:203), Roberts and Alpert (2010:198)
...creates opportunities and involves the intensity of a customer's involvement with the offerings and activities of a business.	Gupta (2012:108), Nammir *et al*. (2012:30), Palmatier *et al*. (2018:3), Sashi (2012:257), Vivek *et al*. (2012:133)
...is characterised by a degree of vigour, dedication, absorption and interaction.	Greve (2014:203), Schaufeli *et al*. (2002:74)

Based on the above existing definitions and universal elements of customer engagement, a definition for this study was formulated as follows:

Customer engagement is a psychological process and behavioural manifestation that goes beyond purchase, satisfaction and retention, which leads to the creation of loyalty, and is characterised by a level of cognitive, emotional and behavioural investment in transactions with the business, as well as the intensity of the customer's involvement with the business' offerings and activities, which is initiated by either the business or customer and can lead to

positive recommendations, where customer engagement is characterised by a degree of vigour, dedication, absorption and interaction.

3.4.2 Importance of customer engagement

In a highly dynamic and collaborative business environment, business practitioners and researchers are increasingly paying more attention to the role and importance of customer engagement (Brodie *et al*., 2011:1). Businesses cannot afford to lose customers as they are considered important intangible assets (Gupta & Lehmann, 2003:9; Hoffman & Bateson, 2017:287; Tripathi, 2009:133).

Customers are becoming more challenging as they are more knowledgeable, connected and even more clever than ever before (Banyte & Dovaliene, 2014:484; IBM, 2010:5). Customers know exactly what they want and are more than prepared to switch to competitors when they are not satisfied, therefore it is extremely important for businesses to explore new ways to keep customers in order to prevent them from switching (Banyte & Dovaliene, 2014:484; Chathoth *et al*., 2014:181; IBM, 2010:5). The necessity of customer engagement is highlighted by the following factors, provided by Tripathti (2014:126-127):

- Control over marketing communications

According to Tripathi (2014:126), businesses are struggling to communicate with customers due to an increasingly fragmented audience and also to break through the clutter to deliver their message. Businesses can use customer engagement to engage and keep customers actively involved (Tripathi, 2009:133).

- Customers are becoming powerful communicators

Blogging and other platforms of social medical have turned customers into powerful communicators as it allow customers to share their views and opinions, discuss and debate, criticise and analyse, as well as interact with businesses (Tripathi, 2014:126). According to Williams (2017:82), these communications are considered to be more important than the business' own communication attempts. Customers now have the ability to communicate when and what they want (Tripathi, 2014:126-127). However, businesses can use the Internet and social media to interact with current and prospective customers to gain a better and faster understanding of their needs (Hudson *et al*., 2016:1; Sashi, 2012:255; Williams, 2017:82).

- Reduced brand loyalty

Customers are struggling to distinguish between brands and getting more confused with the proliferation of goods as brands are becoming more and more similar (Tripathi, 2014:127).

However, customer engagement is seen as a potential differentiator in the customer's purchase decision process (Tripathi, 2009:133). According to Cheung *et al*. (2015:242) and Williams (2017:102), customer engagement leads to the establishment of loyalty. Grimm (2017:2) supports this notion by explaining that highly engaged customers will carry on doing business with a brand, as well as recommend the brand to others.

- Media consumption

The increase of media along with the increase in control over media consumption now provides customers with a better choice as to what media would get consumed (Tripathi, 2014:127). According to Tripathi (2009:134), the best tactic to maintain or improve customer loyalty is by encouraging customer engagement as customers are keen to take part in communication.

According to Roberts and Alpert (2010:198), the success of any business mainly depends on whether customers decide to buy its products or services. Customer engagement is considered a main strategy for creating and maintaining a competitive advantage and a useful predictor of future business results (Brodie *et al*., 2013:105). Businesses can increase their performance, including sales and growth through customer engagement (Roberts & Alpert, 2010:198). Palmatier *et al*. (2018:10) support this notion by explaining that the theory of customer engagement states that if customers are satisfied and have an emotional attachment with the business, then they would be engaged with the business in the form of purchases, recommendations, influence, as well as response. Customer engagement is more than just offering products or services to customers, it is about creating real, more meaningful relationships between customers and the business (Cuillierier, 2016:10; Rupik, 2015:339). Successful customer engagement will result in more than just satisfaction, it will also lead to repeat purchases and recommendations via positive word-of-mouth (Grimm, 2017:2).

3.4.3 Elements of customer engagement

The universal elements of customer engagement that were uncovered in Table 3-1 are discussed below.

3.4.3.1 Customer engagement is a psychological process

According to Nammir *et al*. (2012:27), engagement is considered to be a fundamental concept in psychology literature. Psychology is defined by Robbins *et al*. (2011:10) as the

discipline that aims to assess, describe and adapt human behaviour that includes elements such as learning, insight, character, emotions, wishes and motivational forces, decision-making processes, and measurement of attitudes. According to Vainikka (2015:3,16), psychological factors such as motivation, personality, perception, memory, emotions and attitudes all affect the customer's purchasing behaviour. These factors are used to identify customers' feelings, collect and evaluate information, as well as to formulate thoughts and opinions (Lamb *et al*., 2013:95).

3.4.3.2 Customer engagement creates a collaboration opportunity

Hollebeek (2011a:789) states that customer engagement creates a collaboration opportunity through a two-way interaction between the customer (engagement subject) and the business (engagement object). According to Boyce *et al*. (2016:1), collaboration is seen as a shared practice for businesses to achieve mutual goals. Lai (2011:2) states that collaborative interactions are characterised by mutual goals, the balance of structure, and a high degree of negotiation, interactivity, as well as interdependence. Therefore, collaboration, according to Gummesson (2006:15), is a mutually satisfactory exchange relationship that generates a shared value between the customer and the business. This is specifically crucial in the open medical aid industry in South Africa, as these open medical aid providers face strong opposition and are in a place where they can profit momentously from fulfilling customers' needs and creating the opportunity for collaboration (see section 2.5.4).

3.4.3.3 Customer engagement is characterised by a degree of vigour, dedication, absorption and interaction

According to Nammir *et al*. (2012:30) and Schaulfeli *et al*. (2002:74), customer engagement is a high order structure defined as a constant, emotional state of accomplishment, characterised by vigour, dedication, absorption, as well as interaction:

- **Vigour:** Describes a customer's level of intellectual flexibility and stability during interaction with a business, brand or other customers (Kuvykaitė & Tarutė, 2015:656; Palmatier *et al*., 2018:235). It is characterised by the elevated energy and mental resilience levels of customers, their willingness to invest effort and persistence when faced with issues (Palmatier *et al*., 2018:235; Schaufeli *et al*., 2002:74; Yalabik *et al*., 2015:5). This suggests that strong customers are more likely to be faithful and persistent (Patterson *et al*., 2006:3).

- **Dedication:** Refers to the sense of belonging of a customer to a business and is characterised by a sense of meaning, passion, inspiration, pride and challenge (Palmatier *et al*., 2018:235; Patterson *et al*., 2006:3; Schaufeli *et al*., 2002:74).

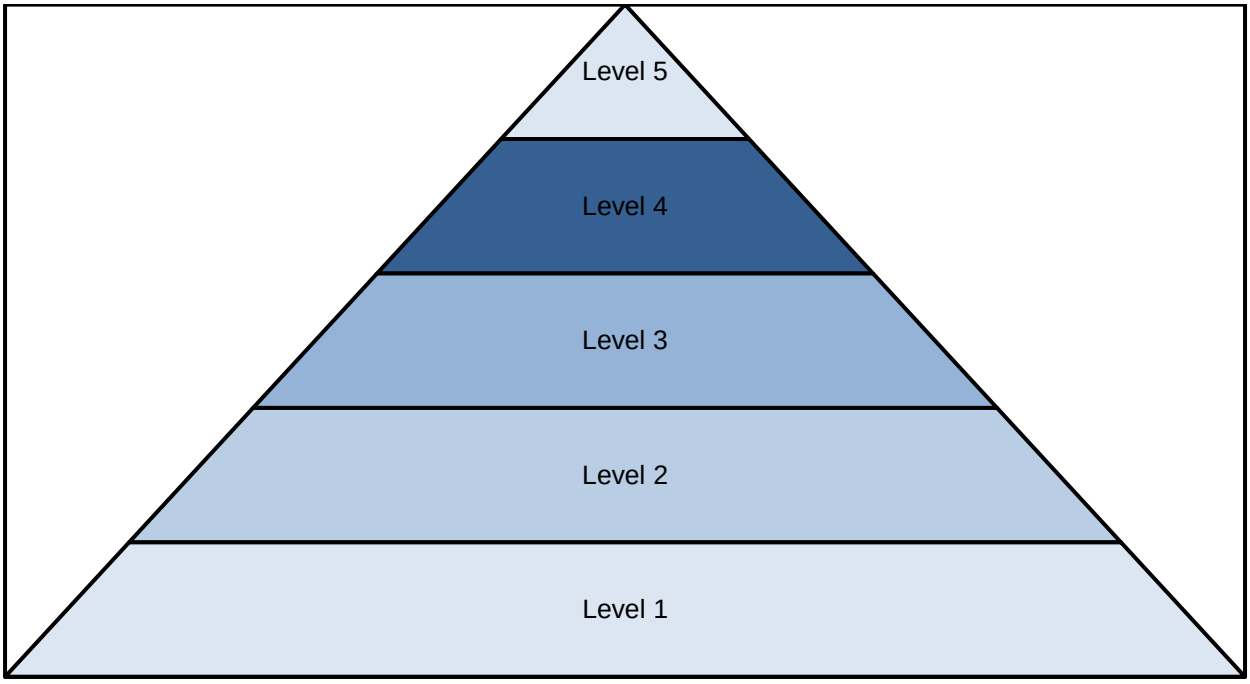
- **Absorption:** Is seen as a high level of concentration and engrossment that represents easy focus, loss of self-consciousness, alteration of time, and intrinsic pleasure (Schaufeli *et al*., 2002:75; So *et al*., 2014:309). According to Nammir *et al*. (2012:30) and So *et al*., (2014:309), absorbed customers feels that time passes quickly when they interact with a business and also find it hard to remove themselves from a business.

- **Interaction:** Refers to a customer's participation with a business or other customers, which can take place online or offline (So *et al*., 2014:309). It is characterised by exchanging ideas, thoughts, as well as feelings regarding experiences with a business (Vivek, 2009:61).

3.4.4 Levels of customer engagement

According to Roberts and Alpert (2010:198), there are several possible levels of customer engagement and each level builds on the previous level(s). These levels are presented in Figure 3-1, followed by a brief description of each level.

Figure 3-1: Levels of customer engagement



Source: Adopted from Roberts and Alpert (2010:198)

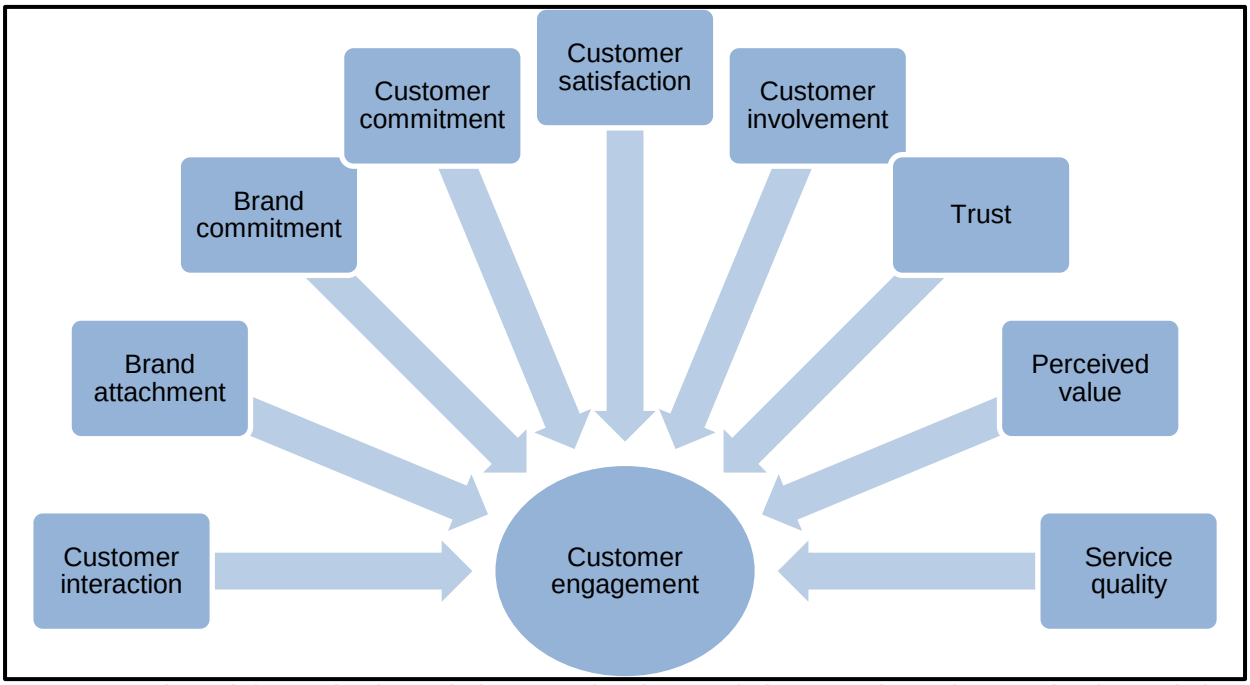
During Level 1, the customer purchases the product or service from the business, which leads to Level 2, where the customer becomes more loyal after the purchase and continues to repurchase the product or service (Roberts & Alpert, 2010:198). At Level 3, the customer now willingly purchases the business' product or service (Roberts & Alpert, 2010:198). During Level 4, the customer starts to occasionally suggest the product or service to others (Roberts & Alpert, 2010:198). And finally, the customer becomes a business supporter at Level 5 and encourages the products or services at every chance (Roberts & Alpert, 2010:198). Referring to the open medical aid industry, the potential customers become customers of an open medical aid provider when they apply for membership. After a brief period, the open medical aid provider's customer becomes more loyal and carry on using the open medical aid provider's services.

According to Roberts and Alpert (2010:198), customers who are at levels 3, 4 and 5 are considered to be truly engaged.

3.4.5 Predictors of customer engagement

As illustrated in Figure 3-2, several predictors of customer engagement were identified from existing literature on customer engagement, such as customer interaction, brand commitment, customer commitment (calculative and affective), customer satisfaction, customer involvement, trust, perceived value and service quality. However, this study will only be focusing on five of the identified predictors, namely customer satisfaction, trust, affective commitment, perceived value and service quality. These constructs were selected based on their relevance to the open medical aid industry.

Figure 3-2: Predictors of customer engagement



Source: Adapted from Floyd *et al*. (2009:186), Kim *et al*. (2013:364), Puriwat and Tripopsakul (2014:42), Rossman *et al*. (2016:543-544), Sashi (2012:260), So *et al*. (2013:407), Thongthip and Jaroenwanit (2016:12), Van Doorn *et al*. (2010:256), and Williams (2017:99).

- **Customer satisfaction**

Customer satisfaction occurs when a business' products and services meet or exceed the customers' expectations (Tripathi, 2014:124). Several businesses consider customer satisfaction to be the starting point of standardising and excellence of performance (Wadud, 2012:17). According to Gummerus *et al*. (2012:860), customer engagement can be encouraged by satisfying customers' needs. Cheung *et al*. (2015:243) support this by stating that high levels of customer satisfaction will lead to high levels of customer engagement.

- **Trust**

Mosavi and Ghaedi (2012:10090) define trust as one party (i.e. the customers) believing that the other party (i.e. the business) will fulfil their needs. According to Eisingerich and Bell (2008:258), a business that constantly meets or exceeds customers' expectations will develop more trusting relationships with its customers. The importance of trust cannot be overemphasised as it is considered to be the basic foundation of any relationship and

necessary for enhancing customer engagement (Sarwar *et al*., 2012:28; Vivek *et al*., 2014:412).

- **Affective commitment**

Affective commitment occurs when individuals feel (emotionally) closer to the business and are also involved with the business and its goals (Sayğan, 2011:220). Affective commitment, as according to Kaptijn (2009:2), has three subcomponents, namely the emotional attachment to the business, followed by the identification with the business and lastly, the involvement in the business. Therefore, affective commitment can be considered a positive predictor of customer engagement (Van Tonder & Petzer, 2018:9).

- **Perceived value**

The value of a product or service, according to Kraim *et al*. (2014:188) and Naylor and Frank (2001:273), is normally regarded as the key element during an exchange. According to Zeithaml (1988:14), the perceived value relates to the complete evaluation by the customer of the usefulness of the product or service based on the perception by the customer of what is received and provided. Yang and Peterson (2004:803) support this statement by explaining that perceived value results from an evaluation of the recompenses and expenses linked with the offering. Research conducted by Hollebeek (2011b:557) and Thongthip and Jaroenwanit (2016:12) state that perceived value can, however, be classified as a predictor of customer engagement.

- **Service quality**

Service quality is defined as the ability of a business to meet or exceed the expectations of customers (Parasuraman *et al*., 1988:14; Ramseook-Munhurrun *et al*., 2010:38). In other words, it is the difference between the customers' expectations of the service and their perceptions of the service provided (Ramseook-Munhurrun *et al*., 2010:39; Zeithaml *et al*., 1990:19). Therefore, according to Kabir and Carlsson (2010:5), if customers' perceptions of the service exceed their expectations, the service will be considered excellent, if customers' perceptions are met by the expectations of the service, the service is considered good, whereas if the customers' perceptions are lower than their expectations, the service is considered bad.

Research conducted by Williams (2017:106) found that researchers are motivated to constantly improve the concept of customer engagement by developing models, frameworks, stages, outcomes and benefits and by revealing the activities that form the foundation of customer engagement, which was discussed in 3.4 3.4. Therefore, this study is aimed to investigate customer satisfaction, affective commitment, trust, perceived value and service quality as predictors of customer engagement in the South African open medical aid industry.

3.5 Conclusion

This chapter demonstrated an increased interest in the academic field on the concept of relationship quality and customer engagement. In addition, a discussion of the theoretical foundation of relationship quality and customer engagement, and important research in relationship quality and customer engagement was summarised. Furthermore, the chapter demonstrated the importance of exploring relationship quality, as well as customer engagement and continued with a review of several definitions of both relationship quality and customer engagement, stating how each was defined from this study. The chapter further recognised the universal elements of customer engagement. Next, the different levels of customer engagement were identified and described. This chapter then concluded with the various predictors of customer engagement. The following chapter provides the research methodology for the study.

CHAPTER 4: RESEARCH METHODOLOGY

4.1 Introduction

This chapter aims to explain the research methodology and the steps of the marketing research process implemented to address the research problem of this study. The chapter commences with defining marketing research and discussing each of the steps of the marketing research process. Then a discussion of the methods selected to address the research problem is provided, with the aim of addressing the specified research objectives. Additionally, the empirical investigation, research design, study population, sample plan, measurement instrument, and the data analysis methods used in the study, are explained.

4.2 Marketing research

The purpose of marketing research, according to Feinberg *et al*. (2013:4), is to improve managerial decisions related to marketing, the economy, as well as to the society holistically by means of collecting information. Every decision made by a business requires the unique collection of information with which significant strategies can be established (Aaker *et al*., 2013:6). Therefore, marketing research is a critical function of marketing and the success of a business, as it inspires informed marketing decisions (Berndt & Petzer, 2011:1). In order for a business to provide customers with superior products or services, marketers need to be alert of the fundamental tendencies in the market environment, and also understand and be able to anticipate the influence that these trends might have on their business (De Meyer-Heydenrych *et al*., 2017:152).

In order to gain a better understanding of marketing research, various definitions of marketing research need to be examined. Consequently, the following section provides different definitions of marketing research that have been adapted from existing marketing literature.

4.2.1 Defining marketing research

The following marketing definitions have been identified from marketing literature over the last decade.

- Beri (2008:4) defines marketing research as an organised and objective study of problems that relate to the marketing of products and services.

- Marketing research is also defined as the relevant data input to assist in making management decisions (Shukla, 2008:14).

- Palmer (2009:149) states that marketing research is about examining a business' overall marketing activities, such as monitoring the success of advertisements, intermediaries, as well as the business' pricing position.

- According to Wiid and Diggines (2009:27), marketing research specifies the data required, the methods to collect, implement and management of the data-collection process, the examination of the results, and lastly, communication of the results and their results to marketing management in to solve the research problem identified.

- Bradley (2010:4) defines marketing research as the process of providing information, in order to assist in making important marketing-related decisions.

- Singh (2010:1) defines marketing research as the function that links consumers to the marketer through data.

- Berndt and Petzer (2011:6) refer to marketing research as the preparation, collection and explanation of data on marketing problems that, in the end, form data that marketing managers can use to make informed decisions.

- Feinberg *et al*. (2013:6) define marketing research as the collection, storage, and examination of data for a particular customer group.

- McDaniel and Gates (2013:4) refer to marketing research as the organising, gathering and examination of data related to decision making, as well as communicating the outcomes.

- Babin and Zikmund (2016:5) view marketing research as the use of scientific methods in searching for the truth regarding the market and marketing phenomena's.

- Zikmund *et al*. (2017:6) state that marketing research can be defined as an objective and systematic process of producing information to assist businesses in making marketing decisions.

Based on the above definitions, marketing research, **for this particular study**, has been defined as an organised and objective process of identifying, collecting, examining,

explaining, and distributing the research results with the main objective of addressing the specified research problem and objectives.

Al-Shatanawi *et al*. (2014:155) state that conducting market research involves several challenges. Therefore, suitable conditions for when to conduct new market research are discussed in the following section.

4.2.2 Conditions suitable for conducting marketing research

The decision to conduct marketing research is determined by the type and nature of the information required (Aaker *et al*., 2013:17). When marketing managers are confronted with an important decision, they must first decide whether it is necessary to conduct marketing research (Zikmund & Babin, 2010:19). According to Burns *et al*. (2017:70), marketing research should be considered when important decisions need to be made. The decision to conduct marketing research is guided by a number of considerations (Malhotra, 2010:46; Sreejesh *et al*., 2014:7). This is indicated in Table 4-1.

Table 4-1: Aspects that determine whether new marketing research needs to be conducted

Factors	Conduct marketing research✓	Do not conduct marketing research✖
Type and nature of information required	No data is available.	Data already exist within the business.
Time	Enough time available before making a decision.	Limited time available.
Availability of resources	Enough funds are available to conduct the research and implement the results.	Insufficient funds are available to implement the results of research.
Benefit versus cost analysis	Benefits of research exceed the costs of conducting research.	Benefits of research do not exceed the costs of conducting research.

Source: Adapted from Aaker *et al*. (2013:17-18) and Zikmund and Babin (2010:21).

The value of marketing research, according to Zikmund and Babin (2010:20), is determined by the nature of the decision that needs to be made. According to Aaker *et al*. (2013:17), research decisions are regularly fixed in time and must be taken according to a specified program, using existing statistics. Sreejesh *et al*. (2014:7) state that both costs and benefits are involved when conducting marketing research. Therefore, marketing research should be

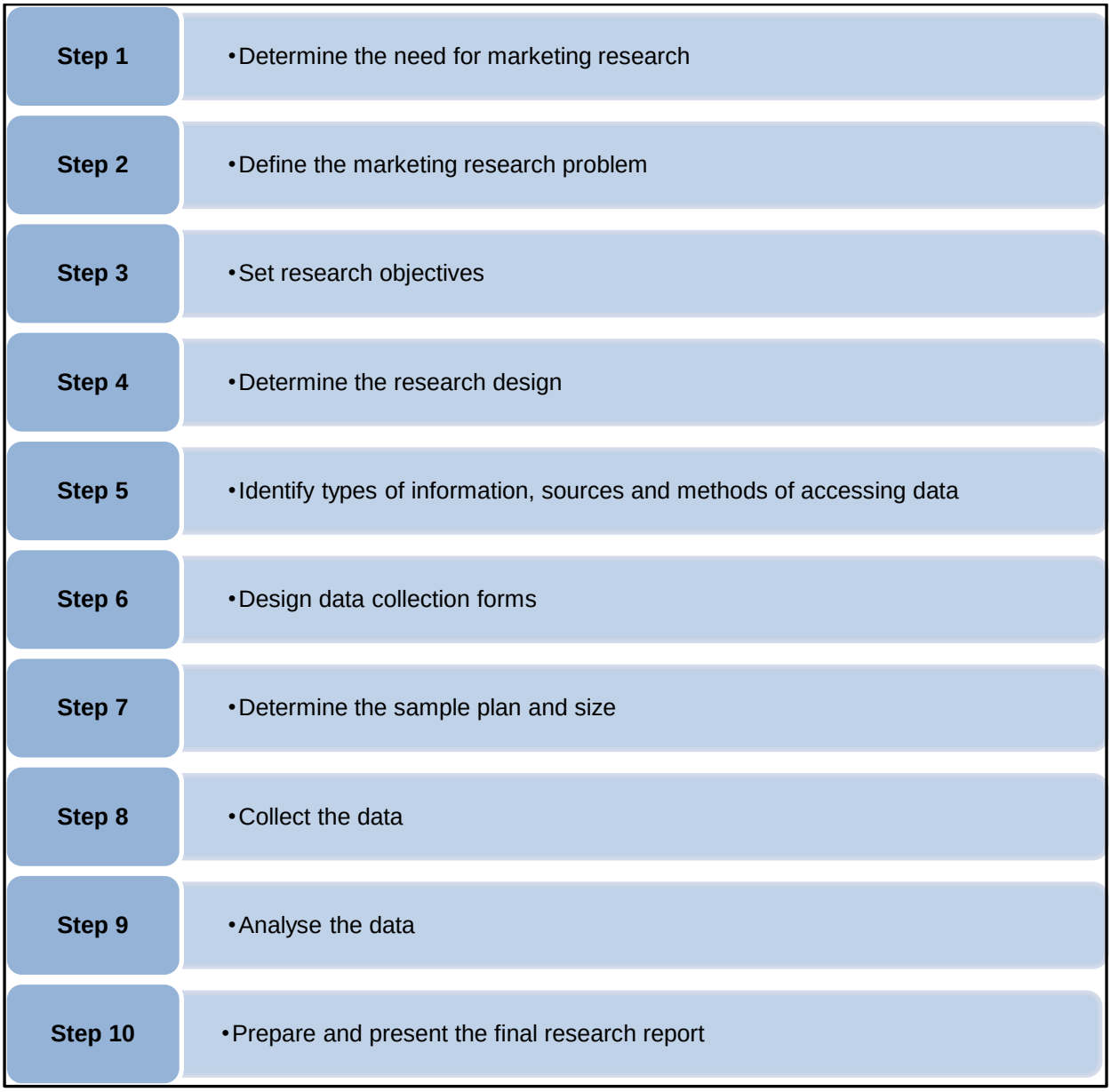
conducted in situations of uncertainty and when the benefits of conducting the research exceed the costs involved in conducting the research (Mooi *et al*., 2018:4).

Several authors consider marketing research as a process (Berndt & Petzer, 2011:3; Churchill *et al*., 2010:5; De-Meyer Heydenrych *et al*., 2017:148; Mooi *et al*., 2018:2). As a result, the marketing research process is discussed in the next section.

4.3 The marketing research process

The marketing research process involves a variety of steps which demonstrates how to conduct marketing research (Berndt & Petzer, 2011:24). The rest of the chapter is based on these steps, which are illustrated in Figure 4-1.

Figure 4-1: The marketing research process



Source: Adapted from Burns *et al*. (2017:68).

For the purpose of this study, the demonstrated outline (in Figure 4-1) of the marketing research process was employed as an outline for the remainder of this chapter.

4.4 Step 1: Determine the need for marketing research

The need to conduct marketing research normally occurs when a business needs to make important decisions, but do not have the necessary information readily available or has limited information (Burns *et al*., 2017:69). The need to conduct marketing research for this study emerged from the detailed literature review provided in Chapters 2 and 3, as well as the inadequate research available on customer engagement in the South African open medical aid industry.

4.5 Step 2: Define the marketing research problem

Defining the research problem is the second step in the marketing research process (Burns *et al*., 2017:71). According to Kumar (2014:64) and Wiid and Diggines (2009:33), this step enables marketers to define the nature and extent of the research problem, so that the research objectives can be established and explained. It is important to define the research problem correctly in order to gather the correct data through the employment of a series of suitable data collection methods (Shukla, 2008:17; Sreejesh *et al*., 2014:14).

Consequently, **for this study**, the research problem and research objectives were identified from existing literature. The research problem was identified and discussed in Chapter 1 (see 1.2) and can be summarised as follows:

> Customers want their medical aid providers to listen to them, help them understand the terms and conditions, and provide them with reliable feedback on a continuous basis. Research shows that medical aid providers are not paying attention to the core of their business (i.e. customers), such as the call centres that interact with their customers on a regular basis. This might be because some medical aid providers have grown so big that it has become difficult for them to continue a personal connection while interacting with their customers (Jensen, 2015). Customers associate most medical service encounters with worry, pain, risk, and sometimes embarrassment, and, therefore, tend to view these encounters as negative experiences. In addition, South Africa's medical aid industry has been rated as one of the lowest when it comes to overall satisfaction, due to complex rules, exclusions, co-payments and the fact that medical aid providers are one of South Africa's highest monthly expenditures (BusinessTech, 2017a; Hunter, 2017; Joubert, 2017; Netwerk24, 2018). Results from SAcsi also revealed that the majority of South Africans are unsatisfied with their current medical aid provider (Consulta, 2019; Medical Plan Advice, 2015).

4.6 Step 3: Establish research objectives

This study sets out to investigate South African customers' engagement with their open medical aid provider. Subsequently, the primary objective of this study is to determine the predictors of customer engagement in the South African open medical aid industry. The following secondary objectives have been formulated to support and achieve the primary objective (refer to Chapter 1, 1.5):

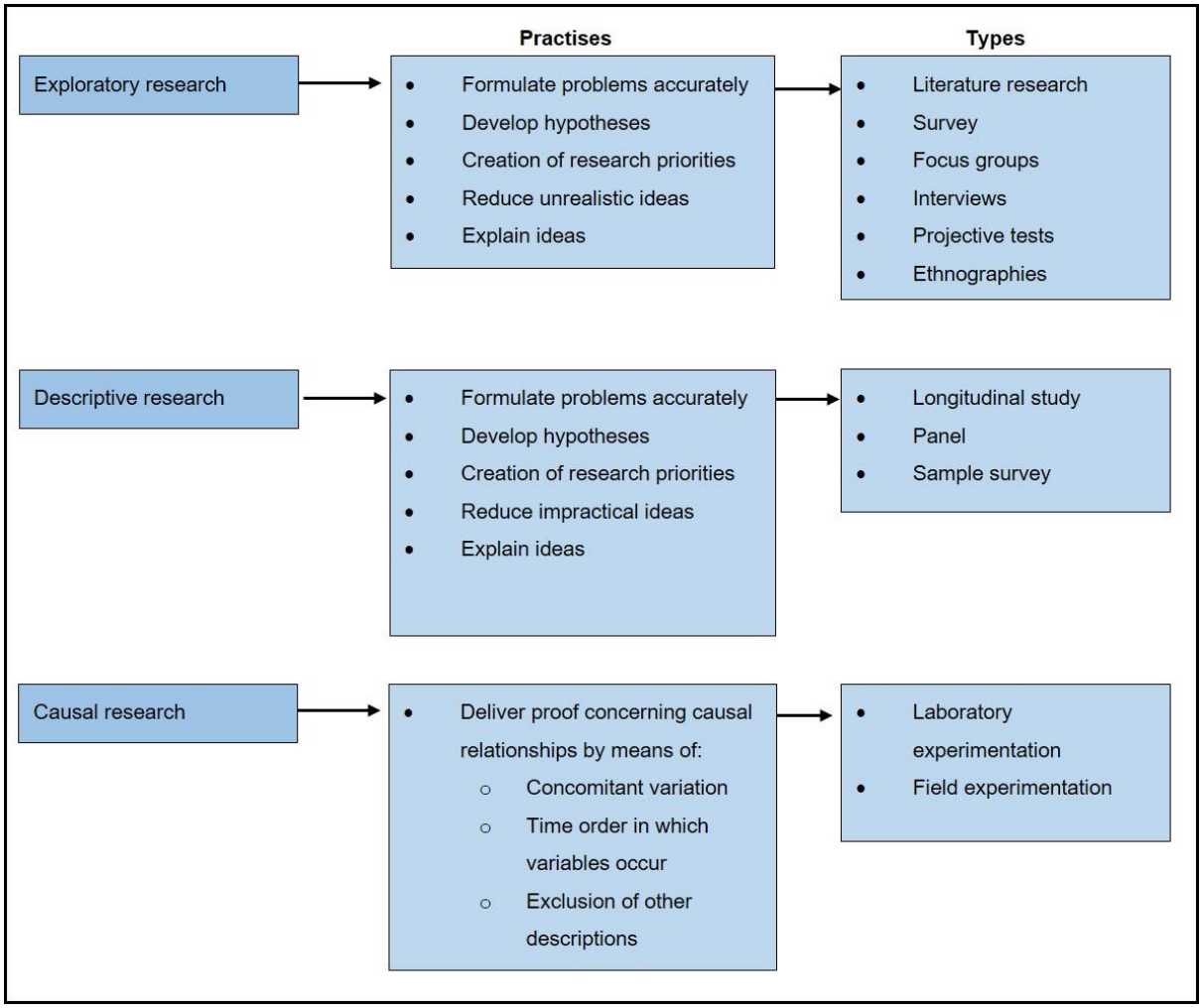
- Compile a sample profile of the open medical aid provider customers who participated in this study.
- Determine respondents' satisfaction with their open medical aid provider.
- Determine respondents' affective commitment towards their open medical aid provider.
- Determine respondents' trust in their open medical aid provider.
- Determine respondents' engagement with their open medical aid provider.
- Determine respondents' value perceptions of their open medical aid provider.
- Determine respondents' service quality perceptions of their open medical aid provider.
- Determine the impact of customer satisfaction, affective commitment, trust, perceived value, and service quality on customer engagement.

4.7 Step 4: Determine the research design

Selecting an appropriate research design requires a great amount of thought, time, and skill (Polaris Marketing Research, 2012:4; Sreejesh *et al*., 2014:16). According to Berndt and Petzer (2011:31), the research design is the strategy that researchers will follow to ensure that the research objectives will be achieved. Smith and Albaum (2010:10) refer to the research design as a plan or framework that is used to conduct research and to collect data.

The research design can, according to Burns *et al*. (2017:93) and Iacobucci and Churchill (2010:58), can be classified into three types, namely exploratory, descriptive, and causal research. The choice of the research design is determined by the research objectives (Burns *et al*., 2017:94). Figure 4-2 provides an overview of the three types of research designs, which is followed by a brief description of each.

Figure 4-2: Types of research designs



Source: Adopted from Iacobucci and Churchill (2010:60).

4.7.1 Exploratory research design

Exploratory research is defined as research design that is unstructured and informal in nature (Burns *et al*., 2017:94). According to Rahi (2017:2), exploratory research is used when a problem or opportunity is unclear and more data is required, and when data needs to be collected that can contribute to important research questions. Iacobucci and Churchill (2010:60) indicate that the purpose of exploratory research is to gain insights and ideas regarding customers' expectations. Burns *et al*. (2017:95) support this notion by explaining that exploratory research is generally used to get background information about the research problem. According to Sreejesh *et al*. (2014:31), exploratory research is used to analyse the

research problem, evaluate other options for solving problems, and to discover new ideas for improvements.

4.7.2 Descriptive research design

In general, descriptive research is used to describe answers to questions such as who, what, where, when, and how (Berndt & Petzer, 2011:32; Burns *et al*., 2017:98; Loeb *et al*., 2017:2-3). Put differently, descriptive research is used to describe something, such as a target market or segment (Berndt & Petzer, 2011:32). Descriptive research, according to Feinberg *et al*. (2013:57), is the most suitable research design to use when the research objectives consist of:

- description of marketing phenomena features and determination of occurrence frequency;
- identify the degree to which marketing variables are connected; and
- generating forecasts about the occurrence of the marketing phenomena.

According to Sreejesh *et al*. (2014:58), descriptive research is also known as survey research, where data is collected through a structured questionnaire, from a sample of individuals that represent the population. Burns *et al*. (2017:99) maintain that descriptive research consists of two types, namely cross-sectional and longitudinal. According to Sreejesh *et al*. (2014:61), a cross-sectional study divides the target population into several segments and then collects data from these segments by means of a sampling method. Feinberg *et al*. (2013:58) state that a cross-sectional study distinguishes itself from other studies, as it is intended to be done just on one occasion, and that the participants cannot be matched up to participants in other studies. A longitudinal study, according to Sreejesh *et al*. (2014:61), uses various surveys to collect data over a period of time. Zikmund and Babin (2010:200) explain that longitudinal studies is used to investigate the continuity of answers and to observe possible differences.

4.7.3 Causal research design

Feinberg *et al*. (2013:59) indicate that causal research is used to accumulate data pertaining to the cause-and-effect relationships that exist in the marketing environment. Zikmund *et al*. (2017:25) explain that the purpose of causal research is to illustrate the causality between occurrences of variables. In other words, causal research deals with the “why” questions, as

it indicates whether a change in one variable would have an effect on another variable (Berndt & Petzer, 2011:32; Nardi, 2018:18).

Taking the research objectives of the study into consideration, **a descriptive research design (cross-sectional) was deemed most appropriate for this study**, as the purpose of the study was to determine the predictors of customer engagement in the South African open medical aid industry. Thus, descriptive research questions are covered by surveying open medical aid (what) customers (who) in the North West Province (where) on what influences their intentions to engage with their open medical aid provider (why).

4.8 Step 5: Identify information types, sources and methods of accessing data

According to De Meyer-Heydenrych *et al*. (2017:155) data has two main forms, namely primary data and secondary data. Secondary data is considered inexpensive, easily accessible and especially useful when a business cannot collect primary data, whereas primary data is required when secondary data fails to provide appropriate information for decision-making (Al-Shatanawi *et al*., 2014:153; Craig & Douglas, 2005:39). However, in most cases, both forms of data are essential to attain the research objectives (Clow & James, 2013:63). As a result, secondary data sources are discussed, followed by primary data sources.

4.8.1 Secondary data sources

Secondary data is existing data that have been collected by another individual or business for their own use, and are usually presented to other researchers for free or at a concessional rate (Sreejesh *et al*., 2014:11). According to Walliman (2011:78), every research study requires secondary data to obtain background information regarding the study. Burns *et al*. (2017:118) support this notion by explaining that secondary data have many uses, therefore, it is rare for a research study to be conducted without containing some form of secondary data. According to Boslaugh (2007:4) and Cheng and Phillips (2014:374), the core advantage of secondary data is that the data have already been collected by another party, therefore saving time and money. However, the use of secondary data also involves a number of problems (Hox & Boeije, 2005:593; Tripathy, 2013:1478). Table 4-2 indicates the advantages and disadvantages of using secondary data.

Table 4-2: Advantages and disadvantages of secondary data

Advantages	Disadvantages
More affordable.	Data can be outdated.
Often have larger sample sizes.	May not fully fit the research problem.
Tend to have more authority.	Hidden errors in the data can occur.
Are usually quick to access.	Generally, contain only factual data.
Are easier to compare to other research using the same data.	No control over the data collection.
Usually provides more data.	In the necessary method (e.g. separate measurement units, definitions) it may not always be recorded.

Source: Adapted from Mooi *et al*. (2018:31).

For the purpose of this study, various academic sources such as marketing journals and textbooks were consulted to conduct a comprehensive literature review in Chapters 2 and 3.

4.8.2 Primary data sources

Primary data is collected straight from respondents by means of data collection methods such as interviews, questionnaires, or direct observations to achieve the research objectives (Sreejesh *et al*., 2014:10, 17). Primary data is primarily collected to solve a specific research problem and can be classified into two forms, namely qualitative and quantitative data (Al-Shatanawi *et al*., 2014:153; Feinberg *et al*., 2013:69). Table 4-3 distinguishes between qualitative and quantitative research.

Table 4-3: Qualitative versus quantitative research

	Qualitative	**Quantitative**
Objective	Gaining a qualitative knowledge of the underlying motivations and reasons.	Quantifying the information and generalising the sample outcomes to the population of interest.
Sample	A small number of cases that are not representative.	A large number of cases that are not representative.
Data collection	Unstructured.	Structured.
Data analysis	Non-statistical.	Statistical.
Outcome	Develop a first knowledge.	Recommend a ultimate course of action.

Source: Adapted from Malhotra *et al*. (2013:171).

The different types of qualitative and data collection techniques are briefly explained in the following sections.

4.8.2.1 Qualitative data collection techniques

According to McCusker and Gunaydin (2015:537), the main aim of qualitative data is to enable the researcher to better understand the experiences and attitudes of a specific group of respondents. Zikmund *et al*. (2017:63) support this statement by explaining that qualitative data techniques allow the researcher to give explanations of phenomena of interest which are used to address the research objectives. According to Mooi *et al*. (2018:82), the most commonly used qualitative data techniques are focus groups, in-depth interviews and projective techniques. A description of each is provided below.

- Focus groups

Focus groups are defined as a discussion between a group of respondents on a certain subject for research purposes (Gill *et al*., 2008:293; Sreejesh *et al*., 2014:51). This discussion is generally semi or highly structured, and is managed by a moderator (Mooi *et al*., 2018:84). The size of the focus group normally involves 6 to 12 respondents, all of whom participate in the discussion for a duration of approximately two hours (Sreejesh *et al*., 2014:51). The moderator begins the discussion by introducing the research subject and providing a brief background about the subject (Mooi *et al*., 2018:84).

- In-depth interviews

Sarstedt and Mooi (2011:78) describe in-depth interviews as having conversations with respondents about a particular topic. In most cases, these respondents are consumers (Mooi *et al*., 2018:82). According to Sreejesh *et al*. (2014:74), these interviews are also known as individual in-depth interviews as they are conducted on an individual basis. Researchers primarily use in-depth interviews to acquire a more comprehensive understanding of respondents' experiences, conditions, or individual perspectives (Hammarberg *et al*., 2016:499).

- Projective techniques

Mooi *et al*. (2018:84) refer to projective techniques as a unique type of testing method, which provides respondents with a provocation and then measures the respondents' reactions or answers. Primarily, projective techniques are used to reveal that which respondents find challenging to articulate, such as emotions, attitudes and beliefs (Sreejesh *et al*., 2014:54).

Mooi *et al*. (2018:84) support this statement by indicating that projective techniques enable respondents to express and fantasise as well as overcoming self-censoring.

4.8.2.2 Quantitative data collection techniques

Al-Shatanawi *et al*. (2014:152) indicate that the aim of quantitative data collection methods is to measure quantity. According to Feinberg *et al*. (2013:236) and Mooi *et al*. (2018:32), quantitative data is related to conclusive research that are generally presented in values. Feinberg *et al*. (2013:236) state that researchers can conduct quantitative research by using two data collection techniques, namely observations and surveys.

- Observations

Observations are referred to as a process where the researcher observes the respondents without getting involved (Sreejesh *et al*., 2014:18). Walliman (2011:10) indicates that there are many forms of observations, depending on the sort of information that is required. Observations enable the researcher to discover certain things that occur in a situation by observing, rather than asking respondents directly (Muijs, 2004:52; Sreejesh *et al*., 2014:18).

- Surveys

Sreejesh *et al*. (2014:17) refer to a survey as a research technique that is used to gain the essential information from respondents by using a questionnaire with pre-determined questions. According to Rowley (2014:308), a questionnaire is designed in a way that empowers a researcher to obtain information without having any direct interaction with the respondents involved.

For the purpose of this study, both primary and secondary data was collected. Primary, quantitative data was collected using self-administered questionnaires to collect information to obtain various answers, such as respondents' perceptions of their open medical aid provider. Secondary data was collected from a selection of academic sources, such as textbooks and marketing journals, which was used to present an extensive literature review (see Chapters 2 and 3). The next section elaborates on the primary data collection process.

4.9 Step 6: Design data collection forms

In this study, the primary data was collected using self-administered questionnaires. Questionnaires are referred to as documents that consist of a collection of open and/or closed questions to which respondents are asked to answer in writing, usually by circling or checking the answers (Rowley, 2014:308). These self-administered questionnaires were physically distributed to various public, high-traffic locations in Klerksdorp, Potchefstroom, and Rustenburg in the North West Province from 27 July 2018 to 9 October 2018. The researcher who received training in fieldwork and marketing research during her honours degree, and had Marketing Research as a module as part of her honours degree, was responsible for the identification of respondents who met the requirements to participate in the study.

4.9.1 Scales of measurement

Measurement is defined as a process of determining a description of objects that is of interest to the researcher and allocating numbers or other symbols to these objects according to pre-specified rules (Burns *et al*., 2017:205; Malhotra *et al*., 2013:280). Mooi *et al*. (2018:35) distinguish between the following four main scales of measurement.

- **Nominal scales** are considered the most basic scale of measurement, which only uses labels (Burns *et al*., 2017:206; Mooi *et al*., 2018:36). According to Feinberg *et al*. (2013:119), nominal scales are used for classification and identification, which is considered the lowest form of measurement. For example, nominal scales can be used to categorise respondents according to their race, gender, home language, or occupation (Burns *et al*., 2017:206).

- **Ordinal scales** provide the researcher with more information than nominal scales, such as an increase or decrease in values (Mooi *et al*., 2018:36). Ordinal scales are known for describing the connection between measures or objects (Feinberg *et al*. (2013:120). It enables the researcher to rank order the answers of the respondents (Burns *et al*., 2017:207).

- **Interval scales** are used to measure the difference between scale points (Hair *et al*., 2013:163). According to Mooi *et al*. (2018:37), interval scales provide researchers with accurate information on the rank at which an object is measured, as well as allow researchers to understand the extent of the differences in values.

- **Ratio scales**, according to Mooi *et al*. (2018:37), provide researchers with the most information. Feinberg *et al*. (2013:124) note that the properties of ratio scales are similar to those of interval scales with a zero point. According to Burns *et al*. (2017:207), respondents find ratio scales simpler to understand as they are in more familiar values, such as years of tertiary education.

4.9.2 Questionnaire design

As mentioned in section 4.8 both primary and secondary data was used. A quantitative research method was used in the form of a self-administered questionnaire. According to Malhotra (2010:335), a self-administered questionnaire is defined as a set of questions designed to obtain information from respondents.

For the purpose of this study, a self-administered questionnaire was used to collect data for the predictors of customer engagement in the South African open medical aid industry. To minimise non-sampling errors, consideration was given to the language, grammar, sentence structure, presentation, and layout of the questionnaire.

This questionnaire consisted of two sections, which include the following:

- **Background information:** This section aimed to obtain information on respondents' demographic background (i.e. age, gender, level of education, and employment status), as well as information regarding respondents' medical aid habits. The purpose of this section was to compile a representative sample profile. The format of the questions was closed-ended questions with set response options and one open-ended question. Table 4-4 provides a summary of the questions included in this section, followed by the response options.

Table 4-4: Background information section

Question / Statement	Source	Response format	Level of measure
In which year were you born?	Self-generated	Open-ended	Nominal
What is your gender?	Self-generated	Dichotomous	Nominal
What is your highest level of education?	Self-generated	Multiple choice	Ordinal

Table 4-4: Background information section (continued)

Question / Statement	Source	Response format	Level of measure
Which ONE of the following best describes your employment status?	Self-generated	Multiple choice	Nominal
What type of medical aid cover do you have with your current medical aid provider?	Self-generated	Multiple choice	Nominal
Overall, how would you rate the cost of your current medical aid provider?	Self-generated	Multiple choice	Nominal

Constructs measurement section: This section aimed to measure respondents' level of agreement with statements regarding their satisfaction, affective commitment, trust, engagement, value perceptions, and service quality perceptions towards their current open medical aid provider. Table 4-5 provides a summary of the questions used to measure each of the related constructs asked in this section of the questionnaire during the data collection.

Table 4-5: Statements of the constructs used for the data collection

Statement	Source	Response format	Level of measure	Secondary objective	Hypothesis
Customer satisfaction					
My decision to get medical coverage with my current medical aid provider was a wise one.	Hellier *et al*. (2003:1798), Mosavi and Ghaedi (2012:10094)	Likert scale	Interval	1	H_1
I feel good about my decision to get medical cover from my current medical aid provider.	Hellier *et al*. (2003:1798), Mosavi and Ghaedi (2012:10094)	Likert scale	Interval	1	H_1
I am pleased that I got medical cover from my current medical aid provider.	Hellier *et al*. (2003:1798), Mosavi and Ghaedi (2012:10094)	Likert scale	Interval	1	H_1
Overall, I am satisfied with my current medical aid provider.	Mosavi and Ghaedi (2012:10094)	Likert scale	Interval	1	H_1
Affective commitment					
I consider myself a loyal customer of my medical aid provider.	Verhoef *et al*. (2002:209)	Likert scale	Interval	3	H_3
I want to remain a customer of my current medical aid provider, because I feel strongly attached to it.	Verhoef *et al*. (2002:209)	Likert scale	Interval	3	H_3
I want to remain a customer of my current medical aid provider, because I feel a strong sense of belonging towards it.	Verhoef *et al*. (2002:209)	Likert scale	Interval	3	H_3
Trust					
My medical aid provider offers me a feeling of trust.	Mosavi and Ghaedi (2012:10094)	Likert scale	Interval	2	H_2
My medical aid provider provides a trustworthy impression.	Mosavi and Ghaedi (2012:10094)	Likert scale	Interval	2	H_2
I have trust in my medical aid provider’s service.	Mosavi and Ghaedi (2012:10094)	Likert scale	Interval	2	H_2

Table 4-5: Statements of the constructs used for the data collection (continued)

Trust					
My medical aid provider can be relied upon to keep promises.	Mosavi and Ghaedi (2012:10094)	Likert scale	Interval	2	H_2
My medical aid provider is trustworthy.	Mosavi and Ghaedi (2012:10094)	Likert scale	Interval	2	H_2
I have complete confidence in my medical aid provider.	Mosavi and Ghaedi (2012:10094)	Likert scale	Interval	2	H_2
Engagement					
My medical aid provider makes me feel like I belong.	Williams (2017:227)	Likert scale	Interval	6	NA
The employees of my medical aid provider makes me feel at home.	Williams (2017:227)	Likert scale	Interval	6	NA
I am proud to be a customer of my medical aid provider.	Williams (2017:227)	Likert scale	Interval	6	NA
My medical aid provider's employees inspire me.	Williams (2017:227)	Likert scale	Interval	6	NA
I care about my medical aid provider's product and service offerings.	Williams (2017:227)	Likert scale	Interval	6	NA
I mostly have positive service interactions with my medical aid provider.	Williams (2017:227)	Likert scale	Interval	6	NA
My medical aid provider keeps its promises.	Williams (2017:227)	Likert scale	Interval	6	NA
My medical aid provider is reliable.	Williams (2017:227)	Likert scale	Interval	6	NA
My medical aid provider has integrity (acts fairly, ethically and openly).	Williams (2017:227)	Likert scale	Interval	6	NA
I feel energised when interacting with my medical aid provider.	Williams (2017:227)	Likert scale	Interval	6	NA

Table 4-5: Statements of the constructs used for the data collection (continued)

Engagement (continued)					
I am completely involved when interacting with my medical aid provider.	Williams (2017:227)	Likert scale	Interval	6	NA
I am willing to put effort into interacting with my medical aid provider.	Williams (2017:227)	Likert scale	Interval	6	NA
I frequently make use of my medical aid provider's products and/or services.	Williams (2017:227)	Likert scale	Interval	6	NA
I frequently participate in the activities of my medical aid provider (such as fundraisers, competitions, etc.)	Williams (2017:227)	Likert scale	Interval	6	NA
Perceived value					
The price of my medical aid provider is low compared to other medical aid providers.	Hellier *et al*. (2003:1798)	Likert scale	Interval	4	H_4
The flexibility of my medical aid provider's product and service offerings is sufficient to meet my needs.	Hellier *et al*. (2003:1798)	Likert scale	Interval	4	H_4
My medical aid provider offers additional financial benefits and assistance.	Hellier *et al*. (2003:1798)	Likert scale	Interval	4	H_4
I can readily understand the exclusions in the policy documents I received from my medical aid provider.	Hellier *et al*. (2003:1798)	Likert scale	Interval	4	H_4
I regard the policy premium I pay to my medical aid provider as acceptable.	Hellier *et al*. (2003:1798)	Likert scale	Interval	4	H_4
I consider the policy I have with my medical aid provider to be a good purchase.	Hellier *et al*. (2003:1798)	Likert scale	Interval	4	H_4

Table 4-5: Statements of the constructs used for the data collection (continued)

Service quality					
When my medical aid provider promises to do something by a certain time, it does so.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
When I have a problem, my medical aid provider shows a sincere interest in solving it.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
My medical aid provider performs its services right the first time.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
My medical aid provider offers its services at the time it promises to do so.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
My medical aid provider keeps error-free records.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
I consider the policy I have with my medical aid provider to be a good purchase.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
The employees of my medical aid provider tell me exactly when services will be performed.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
The employees of my medical aid provider delivers prompt services.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
The employees of my medical aid provider are always willing to help me.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
The employees of my medical aid provider are never too busy to respond to my requests.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
My medical aid provider's employees instil confidence in its customers.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
I feel safe in my transactions with my medical aid provider.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5

Table 4-5: Statements of the constructs used for the data collection (continued)

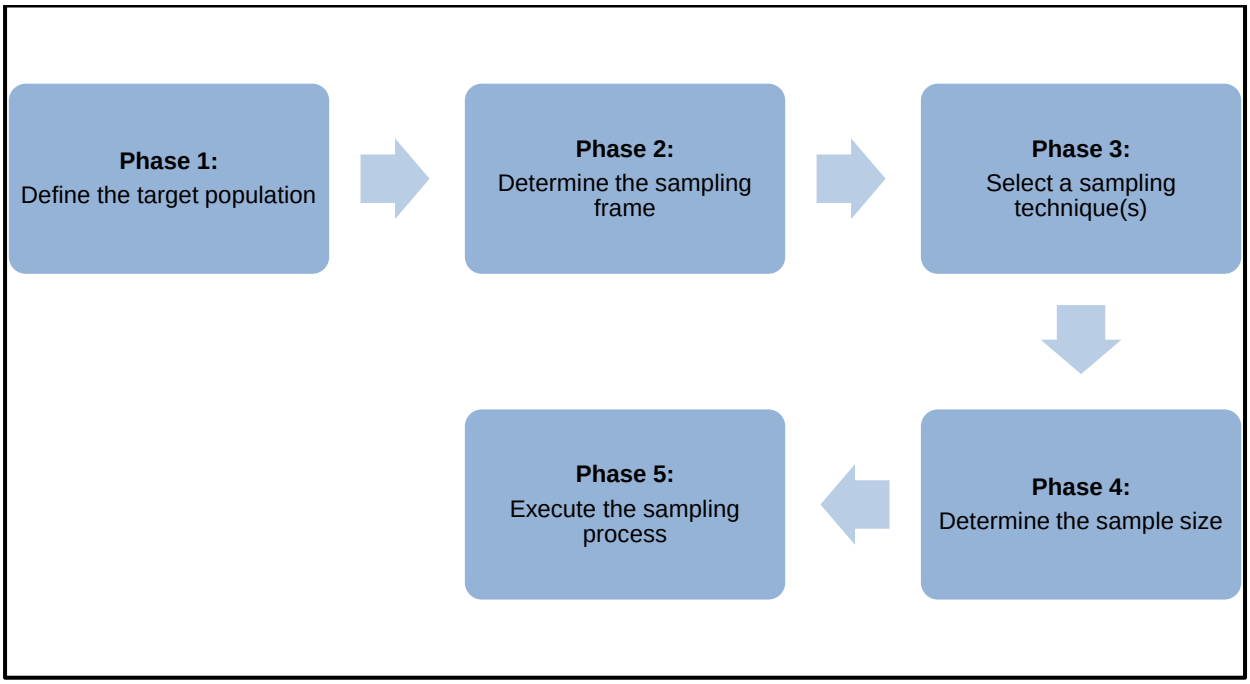
Service quality					
The employees of my medical aid provider are consistently courteous towards me.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
The employees of my medical aid provider have the necessary knowledge to answer my questions.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
My medical aid provider offers me individual attention.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
My medical aid provider has convenient consulting hours.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
The employees of my medical aid provider offers me personal attention.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
My medical aid provider has my best interests at heart.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5
The employees of my medical aid provider understand my specific needs.	Parasuraman *et al*. (1988:38-40)	Likert scale	Interval	5	H_5

The sampling plan will now be discussed in the subsequent sections, followed by a discussion of the data collection.

4.10 Step 7: Determine the sample plan and size

Sreejesh *et al*. (2014:19) refer to a sample as a subset of a larger population. The sampling plan process has six phases, which is presented below in Figure 4-3. A description of each phase is provided below in the following sections.

Figure 4-3: The sampling plan process



Source: Adopted from Malhotra *et al.* (2013:368).

4.10.1 Phase 1: Define the target population

A target population is seen as all the members who have valuable information that the researcher requires in order to determine results and make judgements (Alvi, 2016:10; Malhotra *et al*., 2013:367). In most cases, the target population is indicated in terms of the geographic area, demographic, product or service usage characteristics, or attentiveness measures (McDaniel & Gates, 2013:279).

In this study, the target population consisted of residents of Klerksdorp, Potchefstroom, and Rustenburg (of the North West Province) who have been the principal or primary members

of one of the five major South African open medical aid providers (i.e. Bonitas, Discovery Health, Fedhealth, Medshield, or Momentum Health) for two years or longer.

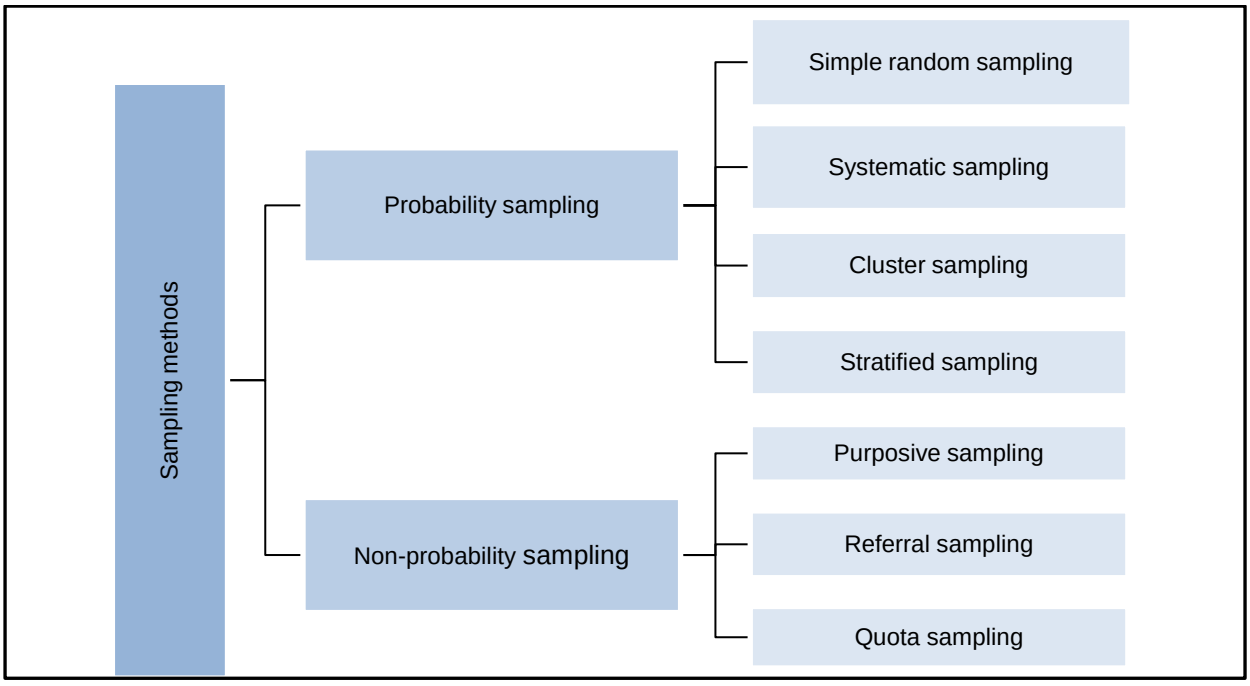
4.10.2 Phase 2: Determine the sampling frame

A sampling frame is defined by Mooi *et al*. (2018:43) as a list of people within a population. Pertaining to the study, an example of a sampling frame would be of a list of people who are members of open medical aid providers. For the purpose of this study, a publically available sampling frame was not available due to the 2013 Protection of Personal Information Act, which forbids open medical aid providers in South Africa to release the personal information of their members. Thus, a sample frame of customers using the products of open medical aid providers in South Africa, could not be attained.

4.10.3 Phase 3: Select the sampling technique

Sampling occurs when a subset is taken from the target population and can be categorised into two types, namely probability sampling and non-probability sampling (Taherdoost, 2016:20). These two types of sampling methods are illustrated in Figure 4-4, followed with a momentary discussion.

Figure 4-4: Sampling methods



Source: Adopted from Burns *et al*. (2017:242, 254).

- **Probability sampling**

With probability sampling, each member of the target sample has a recognised opportunity of being included in the sample (Burns *et al*., 2017:241; Etikan & Bala, 2017:2). According to Alvi (2016:10), an element can be several things, such as a person or a business. However, in this study, the elements are people (members of the five major open medical aid providers in South Africa). As shown in Figure 4-4, probability sampling consists of four methods, each of which are briefly described below.

  - **Simple random sampling** is considered the purest method of probability sampling (McDaniel & Gates, 2013:287) and ensures that every population member has the same chance to participate in the study (Aaker *et al*., 2013:361).

  - **Systematic sampling** entails that the first member of the sample is selected randomly, while the remaining members of the sample will be selected within a certain period of time (Etikan & Bala, 2017:2).

  - **Cluster sampling**, according to Zikmund and Babin (2010:318), is a cost-effective sampling method that recollects the characteristics of a probability sample. It divides the sampling frame into clusters, each of which must be similar to the other clusters (Burns *et al*., 2017:242). The researcher can select one or more of these clusters and use simple random sampling to select observations that represent this particular cluster (Mooi *et al*., 2018:45).

  - **Stratified sampling** is used to divide the population into various subgroups or strata (Etikan & Bala, 2017:2; Feinberg *et al*., 2013:330). In order to create a sample, selected members from each subgroup or strata will be chosen (Etikan & Bala, 2017:2; Shiu *et al*., 2009:474).

- **Non-probability sampling**

With non-probability sampling, each element of the target population has an unknown chance of being part of the sample (Burns *et al*., 2017:241; Etikan & Bala, 2017:1; Feinberg *et al*., 2013:304). As shown in Figure 4-4, non-probability sampling also consists of four methods, each of which are explained below.

- **Convenience sampling** is referred to as a non-probability sample that is selected based on respondents who are easily accessible for the researcher (McDaniel & Gates, 2013:292). According to Etikan *et al*. (2016:2), convenience sampling is also viewed as "accidental" samples, as the population elements might have been selected in the sample merely because they are placed near to where the data collection is being conducted.

- **Purposive sampling** entails that the researcher decides who will take part in the study based on personal judgement (Burns *et al*., 2017:254; McDaniel & Gates, 2013:293). Rahi (2017:3) supports this notion by explaining that the researcher uses own personal judgement to decide which group of consumers knows best about the problem at hand.

- **Referral sampling**, according to Burns *et al*. (2017:254), occurs when respondents are asked to recommend other participants, like themselves, to take part in the study. Etikan and Bala (2017:2) state that this type of sampling method is useful to use when the researcher has little or no information about the target population.

- **Quota sampling** is used by the researcher to recognise quota characteristics, such as demographic or geographic factors, and then to use these quotas to set up small groups of samples for each class of respondent (Burns *et al*., 2017:254; Etikan & Bala, 2017:1). In other words, any individual with similar characteristics will be asked to participate in the study (Etikan & Bala, 2017:1).

For the purpose of this study, the sample was drawn by means of a non-probability sampling method on the basis of convenience and quota sampling. Consequently, screening questions were utilised to ensure that respondents met the criteria for the target population before continuing with the self-administered questionnaire. The purpose of using quota sampling was to obtain equal quotas from the three selected North West Province cities.

4.10.4 Phase 4: Determine the sample size

The sample size indicates the number of respondents included in a study (Creswell & Creswell, 2018:151). Since the nature of the study is problem-solving, the suggested minimum sample size is 200 respondents and the suggested typical sample size ranges

from 300 to 500 (Malhotra, 2010:375). Therefore, to ensure that enough usable questionnaires were collected, as well as to provide for incorrectly completed questionnaires, 356 questionnaires were collected. In addition, the researcher tried to represent the respective open medical aid providers equally. Table 4-6 shows the sampling quotas for the data collection phase.

Table 4-6: Sampling quotas for data collection

City	Gender	Bonitas	Discovery	Fedhealth	Medshield	Momentum	Total
Klerksdorp	Female	15	15	15	15	15	75
	Male	15	15	15	15	15	75
Potchefstroom	Female	15	15	15	15	15	75
	Male	15	15	15	15	15	75
Rustenburg	Female	15	15	15	15	15	75
	Male	15	15	15	15	15	75
Total		90	90	90	90	90	450

4.10.5 Phase 5: Execute the sampling process

As mentioned in sections 4.8.2.2, the sampling elements for this study were chosen based on convenience and accessibility. The sample elements included residents of Klerksdorp, Potchefstroom and Rustenburg (in the North West Province), who had been the primary or principal member of one of the five major open medical aid providers (i.e. Bonitas, Discovery Health, Fedhealth, Medshield, and Momentum), for two years or longer. This is presented in the sample plan in Table 4-7.

Table 4-7: Sample plan of this study

Sampling aspect	Sample description
Target population	Residents of Klerksdorp, Potchefstroom and Rustenburg, who had been the primary or principal member of one of the five open medical aid providers (Bonitas, Discovery, Fedhealth, Medshield and Momentum), for two years or longer.
Sampling frame	No sampling frame was available.
Sampling method	Non-probability; Convenience and quota sampling
Sample size	450 respondents

Sample elements	Respondents in Klerksdorp, Potchefstroom, and Rustenburg, who were accessible during the collection of the data.

4.11 Step 8: Collect the data

The following phase of the marketing research process involved the collection of primary data from the identified population. During this phase, the researcher was responsible for the identification of respondents in Klerksdorp, Potchefstroom, and Rustenburg (in the North West Province), who met the study requirements based on the questionnaire's screening questions, as well as the readiness of respondents to participate in the study. In the context of this study, a total of 356 responses were collected, of which 49 were discarded, leaving a total of 307 usable questionnaires. Due to limited time, the researcher was not able to collect all 450 questionnaires. The data was collected from 27 July 2018 until 9 October 2018. The researcher handed out and collected the questionnaires ensure that the data was not compromised and that the questionnaires were completed correctly. Specific quotas were assigned, as shown in Table 4-, for each open medical aid provider and for each town.

4.12 Step 9: Analyse the data

According to Aaker *et al*. (2013:404), before statistical analysis can be conducted, the raw data acquired from the questionnaires must first endure original preparation. The purpose of data preparation is to take the collected data in its raw form and adapt it to form meaning and create value (Kumar, 2014:294; Shiu *et al*., 2009:494). This includes questionnaire checking, data editing, coding, recording, as well as statistical modifications of the data gathered (Aaker *et al*., 2013:404; Malhotra, 2010:452). According to Malhotra *et al*. (2013:446), questionnaire checking involves checking that all collected questionnaires have been completed. After checking all questionnaires, the researcher can begin with data editing. Editing is the process of reviewing the data for any errors or mistakes that the respondents might have made (Shiu *et al*., 2009:496; Sreejesh *et al*., 2013:163). During the editing process, the researcher uses the screening questions to ensure that only qualified respondents were included in the study and to check for any problems (Hair *et al*., 2013:245; Kumar, 2014:295-296). Pertaining to self-administered questionnaires, the most common problems that occur are partial responses (respondent only answered some questions) and non-responses (De Smith, 2018:82).

The coding of data is described as a process where each respondent's answers are assigned to data categories, as well as assigning numbers to classify each respondent with the categories (Sreejesh *et al*., 2013:167; Smith & Albaum, 2010:262). In other words, coding involves assigning values to the answers to the questions (Mooi *et al*., 2018:98). Once the coding of the questions has been finalised, the researcher can commence with the data entry.

After transferring the data from the questionnaires, the data was entered into SPSS (Statistical Package for Social Science version 25) for statistical analysis (Al-Shatanawi *et al*., 2014:157; Burns *et al*., 2017:73). A total of 49 questionnaires were discarded, as some respondents were not qualified to participate in this study, while others were incomplete. According to Burns *et al*. (2017:317), researchers can use five data analysis techniques, namely descriptive analysis, inferential analysis, difference analysis, association analysis, and predictive analysis to analyse a data set. Feinberg *et al*. (2013:393) state that each data analysis technique contains significant applications for marketing research, therefore, researchers must know which type of analysis best suits the objectives of the study. Consequently, for the purpose of this study, descriptive and inferential testing was used.

Descriptive techniques, according to Feinberg *et al*. (2013:393), is a division of statistics that delivers immediate measures to market researchers for the data in their samples. McDaniel and Gates (2013:343) explain that the most effective way to summarise the characteristics of a large collection of data is to use descriptive statistics. The descriptive statistics used to describe the data for this study consisted of frequencies, percentages, means, and standard deviations. Each of these are presented below in Table 4-8.

Table 4-8: Descriptive statistical techniques used in this study

Technique	Definition	Application of techniques
Frequency	Burns *et al*. (2017:320) state that the frequency distribution indicates the number of times that each number appears in a certain set of numbers.	Table 5-2
Percentage	The percentage distribution is referred to as the proportion of respondents who responded to a question in a specific way, multiplied by 100 (Aaker *et al*., 2013:410).	Table 5-1 Table 5-2
Mean	The mean, according to Aaker *et al*. (2013:410) and Zikmund and Babin (2010:443), is the arithmetic average number gained by dividing the number of responses to a question by the sample size.	Table 5-3 Table 5-4 Table 5-5 Table 5-6

		Table 5-7 Table 5-8 Table 5-12
Standard deviation	According to Burns *et al*. (2017:321), the standard deviation displays the degree of difference in a manner that can be transformed into a normal (or bell-shaped) curve distribution.	Table 5-3 Table 5-4 Table 5-5 Table 5-6 Table 5-7 Table 5-8

For the purpose of this study, the frequencies and percentages of the sample profile of respondents were calculated. In addition, the means and standard deviations were calculated for every statement that measured the constructs of this study (i.e. affective commitment, customer satisfaction, trust, engagement, value perceptions, and service quality).

Nonetheless, according to Burns *et al*. (2017:215), successful research demands that a measure should be reliable, as well as valid. Mohajan (2017:1), supports this notion by explaining that for successful research, reliability and validity are regarded as the two main features in the evaluation of any measurement tool or instrument.

4.12.1 Reliability and validity

Reliability refers to the degree to which the scales used to measure the constructs are free from random errors, whereas validity refers to the degree to which the measurement development is free from random, as well as systematic errors (Feinberg *et al*., 2013:128; Mooi *et al*., 2018:38). According to Zikmund and Babin (2010:248), a measure is considered reliable when diverse measuring efforts have an identical result. Enhancing the execution of reliability will lead to more accurate results, which ultimately increases the chances of making correct decisions in research (Mohajan, 2017:12).

Feinberg *et al*. (2013:132) and McDaniel and Gates (2013:216) state that there are three methods that can be used to measure reliability, namely test-retest reliability (also known as temporal reliability), alternative-forms reliability, and internal consistency. A brief description of each method is provided.

- **Test-retest reliability (also known as temporal reliability)** consists of repeated measurement of the same sample group while using an identical scaling device

under similar circumstances (Feinberg *et al*., 2013:132). According to Mohajan (2017:12), test-retest reliability is gained by managing an identical test two times over a certain period, which can vary from weeks to months, on a group of respondents.

- **Alternative-forms reliability** is determined by providing a group with two different forms that are presumed to be similar to each other and then comparing the results (Feinberg *et al*., 2013:132; McDaniel & Gates, 2013:217).

- **Internal consistency reliability**, according to Pallant (2010:6), is regarded as the extent to which the items that make up the measurement scale are all measuring the matching fundamental element.

For the purpose of this study, the reliability of the constructs (i.e. affective commitment, customer engagement, customer satisfaction, trust, value perceptions, and service quality) were determined by means of Cronbach's alpha coefficients. According to Pallant (2010:97), the scales used to measure these constructs are considered reliable when the Cronbach's alpha coefficient is equal to or exceeds 0.70.

Aaker *et al*. (2013:280) note that a measure is only valid if it measured what it was intended to measure. In other words, validity refers to what is being measured by the instrument, as well as how effective it is being measured (Mohajan, 2017:1). Therefore, validity is seen as the measurement precision (Burns *et al*., 2017:215). Mooi *et al*. (2018:40) indicate that validity can be divided into five forms namely content (also known as face validity), criterion, construct, discriminant, and convergent validity.

- **Content validity** refers to the representativeness, or the suitability of the sample of the content of the measurement instrument (McDaniel & Gates, 2013:218). Silver *et al*. (2013:104) state that the researcher must first decide which elements create an acceptable coverage of the problem in terms of the factors to be assessed in order to evaluate the validity of the content of an instrument.

- **Criterion validity**, according to Malhotra *et al*. (2013:318), concerns the relationship between the scale scores and some other identified assessable criterion.

- **Construct validity** is regarded as the extent to which the measurement instrument signifies, as well as links the perceived phenomenon to the construct by means of the fundamental concept (McDaniel & Gates, 2013:220). In other words, the researcher

evaluates construct validity on how well the measurement instrument measures the constructs that have been theoretically defined (Silver *et al*., 2013:105).

- **Discriminant validity** is referred to as the extent to which a certain measure differs from other constructs (Malhotra *et al*., 2013:319). In other words, discriminant validity is used to confirm which measures in a framework are exclusive, as well as signify phenomena of interest that other measures included in the framework fail to capture (Mooi *et al*., 2018:40).

- **Convergent validity**, according to Malhotra *et al*. (2013:319), is considered to be the extent to which the measure confidently compares with added measures of the similar construct.

For the purpose of this study, both content and construct validity were determined. Content validity was established by developing the self-administered questionnaire based on scales adapted from prior research gathered from the literature review in Chapters 2 and 3. Construct validity was determined by conducting a confirmatory factor analysis (CFA). In other words, the main constructs of this study (i.e. affective commitment, customer engagement, customer satisfaction, trust, value perceptions, and service quality) were validated further by conducting a CFA. The following section discusses the CFA used to determine construct validity.

4.12.2 Confirmatory factor analysis

Multivariate analysis is an addition of univariate and bivariate analysis as multivariate analyses multiple variables (three or more) at a time (Silver *et al*., 2013:218). In addition, multivariate analysis can be further classified into dependence or interdependence techniques (Zikmund *et al*., 2013:584). These multivariate techniques are defined by Feinberg *et al*. (2013:477) and Shiu *et al*. (2009:581-582) as follows:

- **Dependence techniques** are techniques used when one or more variables are recognised as dependent variables to be predicted by the remaining independent variables.
- **Interdependence techniques** involve connecting a set of variables, without attempting to use them to predict other variables.

For the purpose of this study, factor analysis as a multivariate interdependence technique is used. Factor analysis is a statistical procedure used to determine whether a large number of variables share mutual factors that can describe the various connections between the variables (Fabrigar & Wegener, 2012:3; Feinberg *et al*., 2013:482). According to Yong and Pearce (2013:79), the general motive of factor analysis is to outline the data in order to understand and explain the connections between the variables. More specifically, Malhotra *et al*. (2013:622-623) note that factor analysis consists of two approaches, namely confirmatory factor analysis (CFA) and exploratory factor analysis (EFA). CFA is used by researchers to test hypotheses pertaining to the structure underlying a group of variables (Pallant, 2010:181; Yong & Pearce, 2013:79). In other words, a CFA enables researchers to confirm that the relationships between a group of variables are maintained in the new data collections (Chapman & Feit, 2015:222). EFA, on the other hand, is performed to collect data for the purpose of measuring correlations among a group of variables (Chapman & Feit, 2015:209; Pallant, 2010:181). Furthermore, to determine the fit-of-measurement framework, various statistical tests are used in a CFA. Table 4-9 presents the fit indices that were used in this study, accompanied by their recommended cut-off values.

Table 4-9: List of fit indices

Type of fit indices	Description	Recommended cut-off value
CFI	The CFI captures the fit of the hypothesised model as an empirical addition above the baseline model (Iacobucci, 2009:91)	≥ 0.9 > 0.95 = suitable fit Cangur and Ercan (2015:159); Hooper *et al*. (2008:55)
Chi-square (x^2)	Enables the assessment of the number of cases from a sample with hypothesised values (Pallant, 2010:215)	<5.00 (Pallant, 2010:219)
TLI	TLI is recognised as an incremental index and is adjusted for the degrees of liberty between the proposed value and the value models (Cangur & Ercan, 2015:158; Cullinane, 2011:484).	> 0.95 Cangur and Ercan (2015:158); Hu and Bentler (1999:17)
RMSEA	RMSEA is recognised as an absolute fit index, describing the quantity of misfit per degree of liberty between the matrix observed matrix and matrix implied by the model (Chen, 2007:467).	< 0.05 = good fit < 0.08 = suitable fit < 0.10 = ordinary fit Hooper *et al*. (2008:54); Schermelleh-Engel *et al*. (2003:36); Xia and Yang (2018:6)

For the purpose of this study, a CFA was conducted in order to confirm the researcher's theoretical prospects with concern to the factor structure, as well as to conclude whether the concept of the factor structure fits the interpretations made in this particular study. The next section provides a discussion of the standard multiple regression analysis.

4.12.3 Standard multiple regression analysis

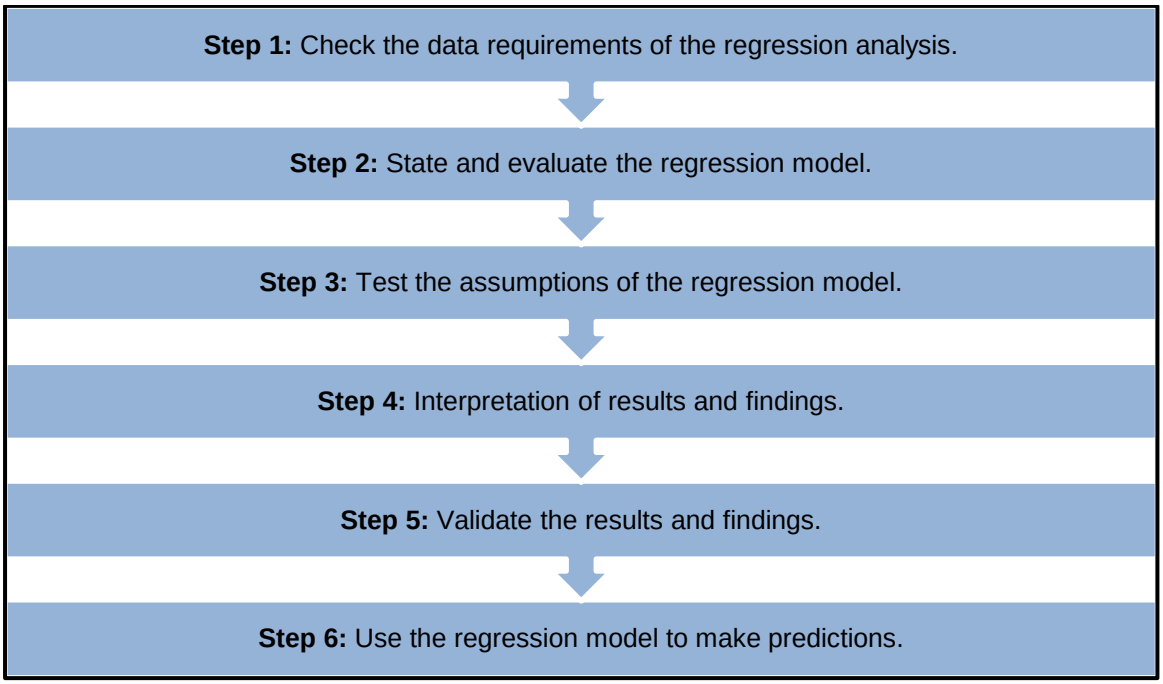
A standard multiple regression is referred to as a type of regression analysis that consists of several independent variables (Mooi *et al*., 2018:401). According to Zikmund *et al*. (2013:586), by using various independent variables, the standard multiple regression analysis is used to foresee a dependent variable. For example, and in context with this study, one dependent variable (customer engagement) is described by one independent variable (i.e. affective commitment) (Zikmund *et al*., 2013:586). Burns *et al*. (2017:412) indicate that even though the addition of independent variables complicates the conceptualisation of the regression situation, it makes the regression model more accurate as the forecasts depend on more than just one factor.

Malhotra *et al*. (2013:566) provide the following universal method of the standard multiple regression:

$$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \ldots + \beta_k X_k + e$$

Furthermore, Mooi *et al*. (2018:219) indicate that there are six steps on how to conduct a standard multiple regression analysis. These steps are presented in Figure 4-5.

Figure 4-5: Steps in conducting a standard multiple regression.



Source: Adopted from Mooi *et al*. (2018:219).

In this study, a standard multiple regression analysis was carried out in order to determine the interrelationship of the constructs shown in the proposed theoretical framework and to test the hypotheses formulated for this study.

4.13 Step 10: Prepare and present the final research report

This is the last step of the marketing research process, as illustrated in Figure 4-1, where the researcher finally draws conclusions from the analysed data, and presents the results in oral or written format (Burns *et al*., 2017:74). This step is applied in more detail in Chapter 5, where the results are presented, and in Chapter 6, where the results are interpreted and discussed.

4.14 Conclusion

This chapter discussed the research methodology followed in the study and the steps of the marketing research process that was implemented. The marketing research process was used as a guideline, from defining the research problem, determining conditions suitable for conducting marketing research, and lastly, to the collection of the data. Furthermore, this chapter provided insight into the data analysis methods used in this study. The final step of the marketing research process is implemented in the following chapters, which involves presenting the research results and providing recommendations.

CHAPTER 5: EMPIRICAL RESULTS AND FINDINGS

5.1 Introduction

The purpose of this chapter is to announce and discuss the results that were obtained from the data analysis (as clarified in Chapter 4). This chapter starts by indicating the sample realisation rate, followed by an overview of the sample of the respondents who participated in the study. Then, the descriptive results are reported, followed by a discussion of the reliability and validity of the measurement scales used. Finally, the hypotheses of this study are addressed by presenting the results of the standard multiple regression analysis.

5.2 Sample realisation rate

As indicated in Chapter 4 (see section 4.3), convenience and quota sampling was used. The researcher approached potential respondents in public places (in Klerksdorp, Potchefstroom, and Rustenburg) to participate in this study. The respondents were selected on a convenience basis while keeping the proposed quotas (as indicated in Table 4-) in mind. Potential respondents were approached by the researcher and kindly asked if they would be willing to take part in the study. If granted, respondents were asked to complete the self-administered questionnaire. If respondents did not wish to participate in the study, the next available respondent was approached.

The aim was to survey 450 respondents (150 respondents from Klerksdorp, 150 respondents from Potchefstroom, and 150 respondents from Rustenburg). Table 5-1 provides a summary of the total respondents who completed the questionnaire, as well as the final sample realisation rate that was achieved.

Table 5-1: Sample realisation rate

Minimum sample size required	450
Number of completed questionnaires	307
Number of questionnaires discarded due to incomplete responses	49
Response rate (307/450 x 100)	68.22%

As seen in Table 5-1, a total of 307 respondents participated in the study, which was less than the initial 450 anticipated. A total of 101 questionnaires were obtained from Klerksdorp, another 104 questionnaires from Potchefstroom, as well as 102 questionnaires from Rustenburg. From the 450 completed questionnaires, 49 were discarded due to incomplete responses, and the rest were not completed, due to the limited available time, which resulted in a response rate of 68.22%. Nonetheless, the final sample of 307 finished questionnaires falls within the minimum sample size range (300 to 500) for conducting data analysis in problem-solving research (Malhotra, 2010:375). Therefore, the sample realisation rate can be considered reliable. The next section specifies the sample profile of the sample realised.

5.3 Sample profile

The questionnaire used in this study included questions that were asked to compile a sample profile. The sample profile included the birth year, gender, level of education, employment status, type of medical aid cover, and cost of medical aid. The birth year was an open question where the respondents had to indicate their year of birth. Furthermore, this data was divided into categories to present the age groups in order to interpret the sample profile more easily.

Table 5-2: Sample profile

Sample profile	Frequencies (F)	Percentage (%)
Year born (age)		
20 to 28 years old	56	18.24
29 to 38 years old	95	30.94
39 to 48 years old	72	23.45
49 to 58 years old	57	18.57
59 and older	24	7.81
Gender		
Male	144	47.06
Female	154	50.33
Level of education		
Primary school completed	1	0.33
Some high school	19	6.21
Matric/grade 12 completed	85	27.78
Technical College diploma	49	16.01

Table 5-2: Sample profile (continued)

Sample profile	Frequencies (F)	Percentage (%)
Level of education (continued)		
University/Technology diploma	44	14.38
University degree (B-degree)	62	20.26
Postgraduate degree (Masters/Doctorate)	46	15.03
Employment status		
Student	10	3.28
Self-employed	40	13.11
Full-time employed	214	70.16
Part-time employed	17	5.57
Housewife/Househusband	7	2.30
Retired	15	4.92
Unemployed	1	0.33
Other	1	0.33
Medical cover		
Savings plan	58	19.27
Hospital plan	110	36.54
Comprehensive plan	113	37.54
Other	20	6.64
Cost of medical aid		
Affordable	39	12.75
Somewhat affordable	52	16.99
Neutral	103	33.66
Somewhat unaffordable	76	24.84
Unaffordable	36	11.76

Table 5-2 indicates that 30.94% of the respondents were between the ages of 29 to 38 years. In terms of gender, 46.91% of the total sample were males and 50.16% were females, therefore both genders are well represented in this study. The majority of the total sample had a technical college/university diploma comprising of 30.39% of the sample. In terms of employment, the majority of the respondents (70.16%) were full-time employed. In addition, Table 5-2 indicates that the majority (37.54%) of the total sample have a comprehensive plan. In terms of cost, 33.66% of respondents rated the cost of their medical aid as neutral, 24.84% as somewhat unaffordable, and 11.76% as unaffordable. Therefore, it can be

concluded that majority (24.84% + 11.76% = 36.49%) of the total sample consider their medical aid provider as expensive.

The main findings concerning the sample profile are as follows:

Main finding 1: The majority of the respondents were females, between the ages 29 and 38 years, with a technical/university diploma, and full-time employed.

Main finding 2: The majority of respondents (37.54) have comprehensive medical cover.

Main finding 3: Most respondents (36.49) consider their medical aid as relatively expensive.

Section B of the questionnaire was intended to obtain information from respondents regarding their satisfaction, affective commitment, trust, engagement, perceived value, and service quality with and towards their current open medical aid providers. The descriptive statistics are reported in the subsequent sections.

5.3.1 Respondents' satisfaction with their current open medical aid providers

The objective of the customer satisfaction measurement was to determine the respondents' level of satisfaction with their current open medical aid providers. In other words, indicating how satisfied or dissatisfied respondents are with their current open medical aid providers. In order to determine this, four statements from previous studies have been adapted regarding customer satisfaction. Respondents had to indicate their level of agreement on an unlabelled five-point Likert scale (where 1 is 'strongly disagree and 5 is 'strongly agree'). The means and standard deviations (SD) for each statement measuring customer satisfaction are presented in Table 5-3.

Table 5-3: Respondents' satisfaction with their current open medical aid providers

Statement	Mean	SD
Customer satisfaction	**3.54**	**0.932**
My decision to get medical coverage with my current medical aid provider was a wise one.	3.49	0.987
I feel good about my decision to get medical cover from my current medical aid provider.	3.59	0.930
I am pleased that I got cover from my current medical aid provider.	3.59	0.963
Overall, I am satisfied with my current medical aid provider.	3.52	1.062

It is clear from Table 5-3 that respondents mostly agreed with the statement "I am pleased that I got cover from my current medical aid provider" (mean = 3.59; SD = 0.963), and "I feel good about my decision to get medical cover from my current medical aid provider," (mean = 3.59; SD = 0.930). The least agreed with statement was, "My decision to get medical coverage with my current medical aid provider was a wise one," (mean = 3.49; SD = 0.987). The following main findings are reported regarding respondents' satisfaction with their current open medical aid providers' services.

Main finding 4: Pertaining to respondents' satisfaction with their current open medical aid providers' services, they generally agreed that they are satisfied with their medical aid providers and that it was a good decision to join their medical aid provider.

Main finding 5: Pertaining to respondents' satisfaction with their open medical aid providers' services, they least agree that to get coverage with their current open medical aid were a wise decision.

5.3.2 Respondents' affective commitment towards their current open medical aid provider

The objective of the affective commitment measurement was to determine the extent to which respondents are committed to their current open medical aid provider. Respondents' affective commitment with and towards their open medical aid providers were measured with three statements that were adjusted from a former study (Verhoef *et al*., 2002:209). Respondents had to indicate their level of agreement on an unlabelled five-point Likert scale

(where 1 is ‘strongly disagree and 5 is ‘strongly agree’). Table 5-4 represents the means and standard deviations (SD) of each statement measuring affective commitment.

Table 5-4: Respondents’ affective commitment

Statement	Mean	SD
Affective commitment	**3.41**	**1.013**
I consider myself a loyal customer of my medical aid provider.	3.63	1.110
I want to remain a customer of my current medical aid provider because I feel strongly attached to it.	3.32	1.068
I want to remain a customer of my current medical aid provider, because I feel a strong sense of belonging towards it.	3.26	1.072

From Table 5-4 it appears that respondents mostly agreed with the statement “I consider myself a loyal customer of my medical aid provider.” (mean = 3.63; SD = 1.110). Respondents least agreed with the statement “I want to remain a customer of my current medical aid provider, because I feel a strong sense of belonging towards it.” (mean = 3.26; SD = 1.072).

The following main findings are reported regarding the respondents’ affective commitment towards their open medical aid providers.

Main finding 6: Concerning respondents’ affective commitment towards their open medical aid providers, they mostly agreed that they are loyal to their open medical aid providers.

Main finding 7: Concerning respondents’ affective commitment towards their open medical aid providers, they least agreed that they want to remain a customer of their current medical aid provider, because they feel a strong sense of belonging towards it.

5.3.3 Respondents’ trust in their current open medical aid provider

The objective of the trust measurement was to evaluate respondents’ trust in their current open medical aid providers. Overall, six statements were adapted from a former study (Mosavi & Ghaedi, 2012:10094) regarding trust. Respondents had to indicate their level of agreement on an unlabelled five-point Likert scale (where 1 is ‘strongly disagree and 5 is ‘strongly agree’). Table 5-5 presents the means and standard deviations (SD) of each statement measuring respondents’ trust.

Table 5-5: Respondents' trust

Statement	Mean	SD
Trust	**3.53**	**0.905**
My medical aid provider offers me a feeling of trust.	3.50	0.954
My medical aid provider provides me a trustworthy impression.	3.54	0.961
I have trust in my medical aid provider's service.	3.57	0.943
My medical aid provider can be relied upon to keep promises.	3.53	0.966
My medical aid provider is trustworthy.	3.56	0.956
I have complete confidence in my medical aid provider.	3.52	0.973

As represented in Table 5-5, respondents mostly agreed with the statement "I have trust in my medical aid provider's service." (mean = 3.57; SD = 0.943). Table 5-5 also indicates that respondents' least agreed with the statement "My medical aid provider offers me a feeling of trust." (mean = 3.50; SD = 0.954).

The main findings regarding respondents' trust are reported as follow:

Main finding 8: Regarding respondents' trust in their open medical aid providers, they mostly agreed that they have trust in their open medical aid providers' services.

Main finding 9: Regarding respondents' trust in their open medical aid providers, they least agreed that their open medical aid providers offer them a feeling of trust.

5.3.4 Respondents' engagement with their current open medical aid provider

The purpose of the customer engagement measurement was to judge the extent to which respondents are engaged with their current open medical aid providers. Respondents' engagement with their current open medical aid providers were measured by using 14 statements that were adapted from a prior study (Williams, 2017:227). Respondents had to indicate their level of agreement on an unlabelled five-point Likert scale (where 1 is 'strongly disagree and 5 is 'strongly agree'). The means and standard deviations (SD) for each statement measuring customer engagement are presented in Table 5-6.

Table 5-6: Respondents' customer engagement

Statement	Mean	SD
Overall customer engagement	**3.25**	**0.807**
My medical aid provider makes me feel like I belong.	3.23	0.961
The employees of my medical aid provider makes me feel at home.	3.23	0.920
I am proud to be a customer of my medical aid provider.	3.39	0.919
My medical aid provider's employees inspire me.	3.09	0.977
I care about my medical aid provider's product and service offerings.	3.41	0.935
I mostly have positive service interactions with my medical aid provider.	3.36	1.013
My medical aid provider keeps its promises.	3.48	0.899
My medical aid provider is reliable.	3.50	0.925
My medical aid provider has integrity (acts fairly, ethically and openly).	3.46	0.923
I feel energised when interacting with my medical aid provider.	3.15	1.003
I am completely involved when interacting with my medical aid provider.	3.27	1.032
I am willing to put effort into interacting with my medical aid provider.	3.32	1.067
I frequently make use of my medical aid provider's products and/or services.	3.32	1.132
I frequently participate in the activities of my medical aid provider (such as fundraisers, competitions, etc.)	2.21	1.221

From Table 5-6 it emerges that respondents mostly agreed with the statement "My medical aid provider is reliable." (mean = 3.50; SD = 0.925) and least agreed with the statement "I frequently participate in the activities of my medical aid provider (such as fundraisers, competitions, etc.)" (mean = 2.21; SD = 1.221).

The following main findings are reported regarding respondents' engagement in their current open medical aid providers.

Main finding 10: Concerning respondents' engagement with their open medical aid providers, they mostly agreed that their medical aid providers are reliable.

Main finding 11: Concerning respondents' engagement with their open medical aid providers, they least agreed that they frequently participate in the activities of their medical aid providers.

5.3.5 Respondents' value perceptions of their current open medical aid provider

The objective of the perceived value measurement was to determine respondents' perception of the value of their current open medical aid providers. In other words, determining respondents' complete valuation of the effectiveness of their current open medical aid provider's services. Respondents' perceived value was measured by using six statements that were adapted from a previously conducted study (Hellier *et al*., 2003:1798). Respondents had to indicate their level of agreement on an unlabelled five-point Likert scale (where 1 is 'strongly disagree and 5 is 'strongly agree'). The means and standard deviations (SD) for each statement measuring perceived value are presented in Table 5-7.

Table 5-7: Respondents' perceived value

Statement	Mean	SD
Perceived value	**3.00**	**0.919**
The price of my medical aid provider is low compared to other medical aid providers.	2.85	1.016
The flexibility of my medical aid provider's product and service offerings is sufficient to meet my needs.	3.14	0.975
My medical aid provider offers additional financial benefits and assistance.	3.06	1.091
I can readily understand the exclusions in the policy documents I received from my medical aid provider.	3.02	1.102
I regard the policy premium I pay to my medical aid provider as acceptable.	2.90	1.099
I consider the policy I have with my medical aid provider to be a good purchase.	3.05	1.127

From Table 5-7 it is clear that respondents frequently agreed with the statement "The flexibility of my medical aid provider's product and service offerings is sufficient to meet my needs." (mean = 3.14; SD = 0.975). The least agreed with statement was "The price of my medical aid provider is low compared to other medical aid providers." (mean = 2.85; SD = 1.016).

The main findings regarding respondents' perceived value are reported as follows:

Main finding 12: Pertaining to respondents' value perceptions of their open medical aid providers, they mostly agreed that the flexibility of their medical aid providers' product and service offerings are sufficient to meet their needs.

Main finding 13: Pertaining to respondents' value perceptions of their open medical aid providers, they least agreed that the price of their medical aid providers are low compared to other medical aid providers.

5.3.6 Respondents' service quality perceptions of their current open medical aid provider

The intention of the service quality measurement was to evaluate the extent to which respondents' expectations are matched by the services provided by their current open medical aid provider. As explained in Chapter 1 (see section 1.4.7), respondents' service quality perceptions was measured by using the SERVQUAL method, which presents five dimensions for measuring service quality, namely tangibility, reliability, responsiveness, assurance, and empathy. However, only four dimensions were used, as the services provided by open medical aid providers are considered intangible. Respondents' service quality perceptions were measured by using 19 statements that were adapted from a previously conducted study (Parasuraman *et al*., 1988:38-40). Respondents had to indicate their agreement on an unlabelled five-point Likert scale (where 1 is 'strongly disagree and 5 is 'strongly agree'). Table 5-8 presents the means and standard deviations (SD) of each statement measuring service quality.

Table 5-8: Respondents' service quality perceptions

Statement	Mean	SD
Service quality	**3.33**	**0.839**
When my medical aid provider promises to do something by a certain time, it does so.	3.38	0.933
When I have a problem, my medical aid provider shows a sincere interest in solving it.	3.30	0.937
My medical aid provider performs its services right the first time.	3.36	0.895
My medical aid provider offers its services at the time it promises to do so.	3.39	0.932
My medical aid provider keeps error-free records.	3.34	0.926
I consider the policy I have with my medical aid provider to be a good purchase.	3.43	1.014
The employees of my medical aid provider tell me exactly when services will be performed.	3.32	0.984

Table 5 8: Respondents' service quality perceptions (cont.)

Statement	Mean	SD
Service quality (continued)	**3.33**	**0.839**
The employees of my medical aid provider delivers prompt services.	3.41	0.971
The employees of my medical aid provider are always willing to help me.	3.41	0.986
The employees of my medical aid provider are never too busy to respond to my requests.	3.29	0.995
My medical aid provider's employees instil confidence in its customers.	3.29	0.960
I feel safe in my transactions with my medical aid provider.	3.44	0.930
The employees of my medical aid provider are consistently courteous towards me.	3.37	0.955
The employees of my medical aid provider have the necessary knowledge to answer my questions.	3.39	0.982
My medical aid provider offers me individual attention.	3.22	1.005
My medical aid provider has convenient consulting hours.	3.47	0.911
The employees of my medical aid provider offers me personal attention.	3.21	0.961
My medical aid provider has my best interests at heart.	3.21	0.965
The employees of my medical aid provider understand my specific needs.	3.23	0.998

Table 5-8: Respondents' service quality perceptions (continued)

Statement	Mean	SD
Service quality (continued)	**3.33**	**0.839**
The employees of my medical aid provider are never too busy to respond to my requests.	3.29	0.995
My medical aid provider's employees instil confidence in its customers.	3.29	0.960
I feel safe in my transactions with my medical aid provider.	3.44	0.930
The employees of my medical aid provider are consistently courteous towards me.	3.37	0.955
The employees of my medical aid provider have the necessary knowledge to answer my questions.	3.39	0.982
My medical aid provider offers me individual attention.	3.22	1.005
My medical aid provider has convenient consulting hours.	3.47	0.911
The employees of my medical aid provider offers me personal attention.	3.21	0.961
My medical aid provider has my best interests at heart.	3.21	0.965
The employees of my medical aid provider understand my specific needs.	3.23	0.998

As represented by Table 5-8, respondents mostly agreed with the statement “My medical aid provider has convenient consulting hours.” (mean = 3.47; SD = 0.911). The least agree with statements were, “The employees of my medical aid provider offer me personal attention” (mean = 3.21; SD = 0.961) and, “My medical aid provider has my best interests at heart.” (mean = 3.21; SD = 0.965).

The following main findings are reported regarding respondents’ service quality of their open medical aid provider:

Main finding 14: Concerning respondents’ service quality perceptions of their open medical aid provider, they mostly agreed that their open medical aid provider has convenient consulting hours.

Main finding 15: Concerning respondents’ service quality perceptions of their open medical aid provider, they least agreed that their open medical aid provider offers them individual attention and that their open medical aid provider has their best interest at heart.

The next section discusses the reliability and validity of the measurement instrument.

5.4 Reliability and validity assessment

The most generally used statistic to measure the reliability of measurement scales is Cronbach’s alpha coefficient (Pallant, 2010:6). Therefore, to assess the reliability of the measurement scales used in this study, the Cronbach’s alpha coefficients of each construct was determined (Tavakol & Dennick, 2011:54).

According to Pallant (2010:6), Cronbach’s alpha coefficient “provides an indication of the average correlation among all the items that make up the scale”. Furthermore, the Cronbach’s alpha has a minimum recommended value of 0.70 and a maximum value of 1.00 (Mazzocchi, 2011:10; Pallant, 2010:6). Table 5-9 presents the Cronbach’s alpha values of the variables customer satisfaction, affective commitment, trust, customer engagement, perceived value, and service quality.

Table 5-9: Cronbach's alpha values

Construct	Cronbach's alpha values
Customer satisfaction	0.938
Affective commitment	0.916
Trust	0.966
Customer engagement	0.957
Perceived value	0.927
Service quality Reliability Responsiveness Assurance Empathy	0.958 0.949 0.947 0.951 0.930

From Table 5-9 it emerges that all the Cronbach's alpha coefficient values are above 0.70, and ranges between 0.85 and 1.00. Therefore, all six constructs that were investigated in this study can be considered reliable.

Main finding 16: Every measurement scales measuring the constructs of customer satisfaction, affective commitment, trust, customer engagement, perceived value, and service quality in this study can be regarded as reliable.

5.4.1 Confirmatory factor analysis (CFA)

A CFA was conducted in order to determine the validity of the proposed theoretical framework, which consisted of the six constructs (i.e. customer satisfaction, affective commitment, trust, customer engagement, perceived value, and service quality) investigated in this study. The investigation comprised of an assessment of convergent, discriminant, as well as construct validity, which are discussed in the subsequent sections.

5.4.1.1 Convergent validity

The standardised factor loadings, standard errors of the effect sizes, as well as the p-value (significance value) for each statement of the six investigated variables, are presented below in Table 5-10.

Table 5-10: Standardised factor loadings, standardised errors and significance values

Variable	Statement	Std. loading	Std. error	p-value*
Customer satisfaction	My decision to get medical coverage with my current medical aid provider was a wise one.	0.881	0.223	0.001*
	I feel good about my decision to get medical cover from my current medical aid provider.	0.930	0.122	0.001*
	I am pleased that I got medical cover from my current medical aid provider.	0.923	0.142	0.001*
	Overall, I am satisfied with my current medical aid provider.	0.853	0.314	0.001*
Affective commitment	I consider myself a loyal customer of my medical aid provider.	0.799	0.446	0.001*
	I want to remain a customer of my current medical aid provider, because I feel strongly attached to it.	0.959	0.094	0.001*
	I want to remain a customer of my current medical aid provider, because I feel a strong sense of belonging towards it.	0.926	0.167	0.001*

Table 5-10: Standardised factor loadings, standardised errors and significance values (continued)

Variable	Statement	Std. loading	Std. error	p-value*
Trust	My medical aid provider offers me a feeling of trust.	0.896	0.183	0.001*
	My medical aid provider provides a trustworthy impression.	0.906	0.170	0.001*
	I have trust in my medical aid provider's service.	0.908	0.158	0.001*
	My medical aid provider can be relied upon to keep promises.	0.923	0.141	0.001*
	My medical aid provider is trustworthy.	0.928	0.130	0.001*
	I have complete confidence in my medical aid provider.	0.893	0.196	0.001*
Customer engagement	My medical aid provider makes me feel like I belong.	0.835	0.282	0.001*
	The employees of my medical aid provider makes me feel at home.	0.848	0.239	0.001*
	I am proud to be a customer of my medical aid provider.	0.878	0.195	0.001*
	My medical aid provider's employees inspire me.	0.792	0.357	0.001*
	I care about my medical aid provider's product and service offerings.	0.821	0.286	0.001*
	I mostly have positive service interactions with my medical aid provider.	0.863	0.261	0.001*
	My medical aid provider keeps its promises.	0.880	0.186	0.001*
	My medical aid provider is reliable.	0.880	0.194	0.001*
Customer engagement (continued)	My medical aid provider makes me feel like I belong.	0.876	0.199	0.001*
	I feel energised when interacting with my medical aid provider.	0.792	0.376	0.001*
	I am completely involved when interacting with my medical aid provider.	0.784	0.411	0.001*
	I am willing to put effort into interacting with my medical aid provider.	0.764	0.477	0.001*
	I frequently make use of my medical aid provider's products and/or services.	0.627	0.777	0.001*
	I frequently participate in the activities of my medical aid provider (such as fund raisers, competitions, etc.)	0.483	1.145	0.001*

Table 5-10: Standardised factor loadings, standardised errors and significance values (continued)

Variable	Statement	Std. loading	Std. error	p-value*
Perceived value	The price of my medical aid provider is low compared to other medical aid providers.	0.680	0.559	0.001*
	The flexibility of my medical aid provider's product and service offerings is sufficient to meet my needs.	0.814	0.322	0.001*
	My medical aid provider offers additional financial benefits and assistance.	0.803	0.430	0.001*
	I can readily understand the exclusions in the policy documents I received from my medical aid provider.	0.832	0.383	0.001*
	I regard the policy premium I pay to my medical aid provider as acceptable.	0.888	0.262	0.001*
	I consider the policy I have with my medical aid provider to be a good purchase.	0.922	0.196	0.001*
Service quality	Reliability	0.942	0.083	0.001*
	Responsiveness	0.926	0.122	0.001*
	Assurance	0.928	0.113	0.001*
	Empathy	0.900	0.144	0.001*

*p<0.001

From Table 5-10, it is evident that the factor loadings of all measurement variables are noteworthy and beyond the recommended threshold of 0.50 (Hair *et al*., 2014:115), which indicates that all factors loaded significantly on their respective constructs and can be retained in the framework.

Table 5-11 provides a summary of the CR (composite reliability) and AVE (average variance extracted values) for each construct.

Table 5-11: Test for composite reliability and convergent validity

Variable	CR	AVE
Customer satisfaction	0.941	0.805
Affective commitment	0.911	0.805
Trust	0.968	0.827
Customer engagement	0.958	0.643

Table 5-11: Test for composite reliability and convergent validity (continued)

Variable	CR	AVE
Perceived value	0.919	0.683
Overall service quality	0.967	0.854
Acceptable value	>0.70	>0.50

Additionally, Table 5-11 indicates that the CR values range from 0.911 to 0.968, which indicates strong internal consistency, as these values are all above the threshold value of 0.70 (Hair *et al*., 2013:46).

Main finding 17: With regard to each variable, the CR values show strong internal consistency.

The AVE values should be greater than the recommended norm of 0.50 (Ahmad *et al*., 2016:7; Fornell & Larcker, 1981:46). As evident from Table 5-11 the AVE values ranged from 0.643 to 0.854, indicating that all exceed 0.50. Therefore, in view of these findings, followed by the results from the factor loadings, as well as the construct reliabilities, it can be established that the variables of customer satisfaction, affective commitment, trust, customer engagement, perceived value and service quality are reliable and demonstrate good convergent validity.

Main finding 18: All six constructs of the measurement framework (i.e. customer satisfaction, affective commitment, trust, customer engagement, perceived value, and service quality) have reliability and convergent validity.

5.4.1.2 Discriminant validity

Discriminant validity was used to determine whether the variables measured are different from one another (Ghadi *et al*., 2012:140). Table 5-11 indicates that the AVE for each construct was above the common variance between any two constructs. For instance, the largest covariance was between customer engagement (AVE = 0.643) and service quality (AVE = 0.854).

Main finding 19: The AVE values provide proof that all six constructs have discriminant validity.

5.4.1.3 Summary of model validity

Validity is called the accuracy of a concept measured in a study (Heale & Twycross, 2015:66). In other words, a study is valid if it measures what it was intended to measure (Bradley, 2010:60). Content validity (also known as face validity) and construct validity were examined in this study. Furthermore, the six constructs (customer satisfaction, affective commitment, trust, customer engagement, perceived value, and service quality) were further validated by conducting a CFA. As explained in section 5.5.1, the results of the CFA provided proof of convergent and discriminant validity.

Main finding 20: Content validity was obtained, indicating that the measurement statements measured what they were intended to measure.

Main finding 21: Construct validity was achieved, which delivered proof that the constructs measured are different from one another and that for every construct measured, the appropriate measurement statements connected to the construct have a high level of mutual variance.

Finally, Table 5-12 provides a summary of the overall mean scores for all six final constructs.

Table 5-12: Overall mean score

Construct	Statements	Overall mean score
Customer satisfaction	Statement 1 to 4	3.54
Affective commitment	Statement 5 to 7	3.41
Trust	Statement 8 to 13	3.53
Customer engagement	Statement 14 to 27	3.25
Perceived value	Statement 28 to 33	3.00
Service quality	Statement 34 to 52	3.33

For the six constructs, the mean values vary between 2.99 and 3.54. The constructs were measured on an unlabelled five-point Likert scale (where 1 is ‘strongly disagree and 5 is ‘strongly agree’). Therefore, it is clear that the overall mean scores for all constructs used are moderately positive. Main findings 22 to 27 are presented below.

Main finding 22: The complete mean scores for respondents’ satisfaction with their open medical aid provider are above the mid-point of the measurement scale, which shows that respondents are

satisfied with their open medical aid provider.

Main finding 23: The overall mean scores for respondents' affective commitment towards their open medical aid provider are above the mid-point of the measurement scale, indicating that respondents exhibited affective committed towards their open medical aid providers.

Main finding 24: The total mean scores for respondents' trust in their open medical aid provider are above the mid-point level, meaning that respondents display trust in their open medical aid provider.

Main finding 25: The general mean scores for respondents' engagement with their open medical aid provider is above the mid-point level, which indicates that respondents demonstrate some form of engagement with their open medical aid provider.

Main finding 26: The overall mean scores for respondents' value perceptions of their open medical aid provider are just below the mid-point level, which shows that respondents perceived open medical aid provider services as somewhat valuable.

Main finding 27: The complete mean scores for respondents' service quality perceptions of their open medical aid provider are above mid-point level, which shows that respondents' expectations are being fulfilled by their open medical aid provider.

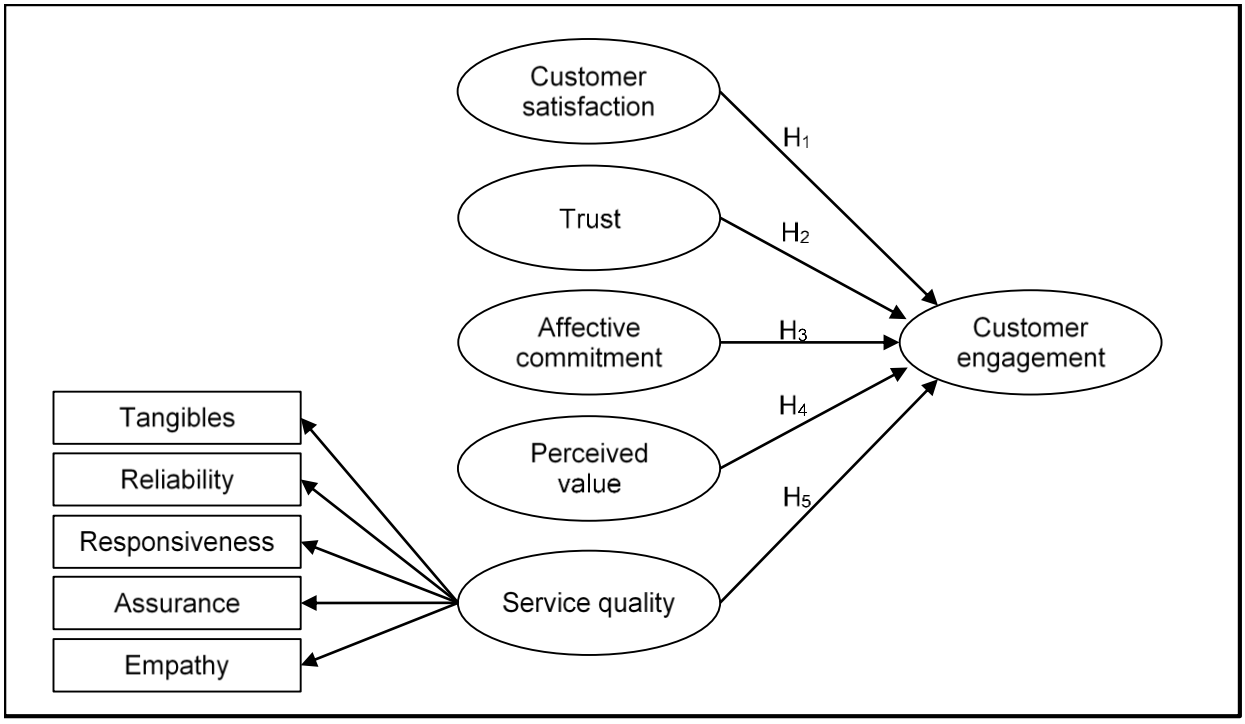
5.5 Evaluating the assumptions of a standard multiple regression

The proposed theoretical framework of this study, as discussed in Chapter 1 and presented below in Table 5-1, was assessed by means of a standard multiple regression analysis. However, before a standard multiple regression analysis can be conducted, certain assumptions for standard multiple regression analysis have to be met. In this study, five independent variables (customer satisfaction, affective commitment, trust, perceived value and service quality) were tested, therefore, a minimum sample size of 90 respondents were required (Pallant, 2010:150). This study achieved a sample size of 307 respondents, which is well above the minimum requirements.

In addition, the findings showed that the multicollinearity between the five independent variables range from 0.644 to 0.870, which indicates that the multicollinearity is not too high

(r<0.9) and that no outliers were identified. As a result, a standard multiple regression analysis can be conducted.

Figure 5-1: Proposed theoretical framework



5.5.1 Standard multiple regression results

The Pearson coefficient correlation was conducted as part of the standard multiple regression analysis. These results showed that there are significant linear relationships customer satisfaction, affective commitment, trust, perceived value, and service quality) and the dependent variable (customer engagement) with p-values < 0.05. The correlations range between 0.756 and 0.870, which are strong.

Table 5-13 presents a model summary in which a R^2 of 0.820 is evident. This indicates that 82% of the variability in customer engagement can be allocated to the five constructs (predictors). The results of the ANOVA are represented in Table 5-14, which indicates that at least one regression weight is significantly diverse from being 0 (p-value = 0.000).

Table 5-13: Model summary

Model	R	R^2	Adjusted R^2	Std. error of the estimate
1	0.906[a]	0.820	0.817	0.346

[a] Predictors: (Constant), customer satisfaction, affective commitment, trust, perceived value, and service quality

Table 5-14: ANOVA

Model		Sum of squares	df	Mean square	F-value	p-value
1	Regression	161.733	5	32.347	270.254	0.000*
	Residual	35.428	296	0.120		
	Total	197.161	301			

* p-value at significance level of 0.000.

Furthermore, Table 5-15 indicates that the p-value for the constant is 0.008, which is less than 0.05. Thus, the framework is considered valid.

Table 5-15: Coefficients

Model		Standard coefficient β-value	t	p-value
1	Constant		2.665	0.008*
	Customer satisfaction	0.022	0.426	0.671
	Affective commitment	0.137	3.262	0.001*
	Trust	0.285	5.222	0.000*
	Perceived value	0.131	3.153	0.002*
	Service quality	0.410	7.541	0.000*

*p-value < 0.05 is statistically significant

The hypotheses that were formulated for this study are summarised and presented in Table 5-16.

Table 5-16: Alternative hypotheses formulated for this study

Hypotheses
H1: Customer satisfaction has a positive and significant impact on customer engagement.
H2: Customer trust has a positive and significant impact on customer engagement.
H3: Affective commitment has a positive and significant impact on customer engagement.
H4: Perceived value has a positive and significant impact on customer engagement.
H5: Service quality has a positive and significant impact on customer engagement.

The regression results are summarised and presented in Table 5-17, and explained.

Table 5-17: Direct effects of hypothesis testing

Hypothesis	Relationship	Std.β	S.E.	p-value
H1	Customer satisfaction ➔ Positive impact on customer engagement	0.022	0.045	0.671
H2	Trust ➔ Positive impact on customer engagement	0.285	0.049	0.000*
H3	Affective commitment ➔ Positive impact on customer engagement	0.137	0.033	0.001*
H4	Perceived value ➔ Positive impact on customer engagement	0.131	0.036	0.002*
H5	Service quality ➔ Positive impact on customer engagement	0.410	0.053	0.000*

*p-value < 0.05 is statistically significant

The regression results revealed that customer satisfaction does not have a significant positive impact on customer engagement (β = 0.022; S.E. = 0.045; p-value = 0.671; rejecting $\mathbf{H_1}$). In terms of trust, from Table 5-17, it emerges that trust had a positive significant impact on customer engagement (β = 0.285; S.E. = 0.049; p-value = 0.000; accepting $\mathbf{H_2}$). Furthermore, both affective commitment (β = 0.137; S.E. = 0.033; p-value = 0.001; accepting $\mathbf{H_3}$) and perceived value (β = 0.131; S.E. = 0.036; p-value = 0.002; accepting $\mathbf{H_4}$) had a positive significant impact on customer engagement. Lastly, service quality had a positive significant impact on customer engagement (β = 0.410; S.E. = 0.053; p-value = 0.000; accepting $\mathbf{H_5}$).

From Table 5-17, it is obvious that service quality displayed the strongest impact on customer engagement (β = 0.410; S.E. = 0.053; p-value = 0.000). As mentioned in section 1.4.7, service quality is an element of whether a customer will stay with or defect from a business (Zeithmal *et al*., 1996:33). For that reason, it can be decided that delivering quality services can lead to customer engagement. Furthermore, customer satisfaction displayed no positive significant impact on customer engagement (β = 0.022; S.E. = 0.045; p-value = 0.671), most probably since customer satisfaction is correlated highly with the other predictors. Trust displayed the second strongest impact on customer engagement (β = 0.285; S.E. = 0.049; p-value = 0.000). Trust is seen as the basis on which customers build business relationships (Persaud & Bonham (2018:26; Sakallaris *et al*., 2016:54). It can be concluded that if customers trust their open medical aid providers, they will be more agreeable to release any private or personal information, interact, and be more involved with their open medical aid providers (Persaud & Bonham, 2018:26).

As a result, the main findings relating to the hypotheses formulated for this study are presented below.

Main finding 28: Customer satisfaction does not have a positive and significant impact on customer engagement.

Main finding 29: Trust has a positive and significant impact on customer engagement.

Main finding 30: Affective commitment has a positive and significant impact on customer engagement.

Main finding 31: Perceived value has a positive and significant impact on customer engagement.

Main finding 32: Service quality has a positive and significant impact on customer engagement.

As represented in Table 5-17, customer satisfaction does not have a positive and significant impact on customer engagement and was, therefore, removed from the framework. From Table 5-17, it is evident that an improvement in the four predictors, namely trust, affective

commitment, perceived value and service quality will positively and significantly improve customer engagement in the South African open medical aid industry.

5.6 Summary of the main findings according to the research objectives

A summary of the main findings linking to each secondary objective of the study are presented in Table 5-18.

Table 5-18: Summary of the main findings according to the secondary objectives

Secondary objective 1: Compile a sample profile of existing open medical aid provider customers who participated in this study.	
Main finding 1	The majority of the respondents were females, between the ages 29 and 38 years, with a technical/university diploma, and full-time employed.
Main finding 2	Most respondents (37.54%) have comprehensive medical cover.
Main finding 3	The majority of respondents (36.49%) consider their medical aid as relatively expensive.
Secondary objective 2: Determine respondents' satisfaction with their open medical aid provider.	
Main finding 4	Pertaining to respondents' satisfaction of their open medical aid providers' services, they generally agreed that they are pleased with their current medical aid providers and that it was a good decision.
Main finding 5	Pertaining to respondents' satisfaction with their open medical aid providers' services, they agreed least that to get coverage with their current open medical aid were a wise one.
Secondary objective 3: Determine respondents' affective commitment towards their open medical aid provider.	
Main finding 6	Concerning respondents' affective commitment towards their open medical aid providers, they mostly agreed that they are loyal to their open medical aid providers.
Main finding 7	Concerning respondents' affective commitment towards their open medical aid providers, they least agreed that they want to remain a customer of their current medical aid provider, because they feel a strong sense of belonging towards it.
Secondary objective 4: Determine respondents' trust in their open medical aid provider.	
Main finding 8	Regarding respondents' trust in their open medical aid providers, they mostly agreed that they have trust in their open medical aid providers' services.
Main finding 9	Regarding respondents' trust in their open medical aid providers, they least agreed that their open medical aid providers offer them a feeling of trust.
Secondary objective 5: Determine respondents' engagement with their open medical aid provider.	
Main finding 10	Concerning respondents' engagement in their open medical aid providers, they mostly agreed that their medical aid providers are reliable.
Main finding 11	Concerning respondents' engagement in their open medical aid providers, they least agreed that they frequently participate in the activities of their medical aid providers.

Table 5-18: Summary of the main findings according to the secondary objectives (continued)

Secondary objective 6: Determine respondents' value perceptions of their open medical aid provider.	
Main finding 12	Pertaining to respondents' value perceptions of their open medical aid providers, they mostly agreed that the flexibility of their medical aid providers' product and service offerings are sufficient to meet their needs.
Main finding 13	Pertaining to respondents' value perceptions of their open medical aid providers, they least agreed that the price of their medical aid providers is low compared to other medical aid providers.
Secondary objective 7: Determine respondents' service quality perceptions of their open medical aid provider.	
Main finding 14	Concerning respondents' service quality perceptions of their open medical aid provider, they mostly agreed that their open medical aid provider has convenient consulting hours.
Main finding 15	Concerning respondents' service quality perceptions of their open medical aid provider, they least agreed that their open medical aid provider offers them individual attention and that their open medical aid provider has their best interest at heart.
Secondary objective 8: Determine the impact of customer satisfaction, affective commitment, trust, perceived value, and service quality on customer engagement.	
Main finding 16	All the measurement scales measuring the constructs of customer satisfaction, affective commitment, trust, customer engagement, perceived value, and service quality can be regarded as very reliable since they all show high reliability.
Main finding 17	With regard to each variable, the CR values show strong internal consistency.
Main finding 18	All six constructs of the measurement framework (customer satisfaction, affective commitment, trust, customer engagement, perceived value and service quality) have strong reliability and convergent validity.
Main finding 19	The AVE values provide proof that all six constructs have discriminant validity.
Main finding 20	Content validity was obtained, indicating that the measurement statements measured what they were intended to measure.
Main finding 21	Construct validity was achieved, which provided proof that the constructs measured are different from one another and that for every construct measured, the appropriate measurement statements connected to the construct have a high level of variance in common.
Main finding 22	The overall mean scores for respondents' satisfaction with their open medical aid provider are above the mid-point of the measurement scale, which shows that respondents are satisfied with their open medical aid provider.
Main finding 23	The overall mean scores for respondents' affective commitment towards their open medical aid provider are above the mid-point of the measurement scale, indicating that respondents displayed affective committed towards their open medical aid providers.
Main finding 24	The overall mean scores for respondents' trust in their open medical aid provider are above the mid-point level, meaning that respondents display trust in their open medical aid provider.

Table 5-18: Summary of the main findings according to the secondary objectives (continued)

Secondary objective 8: Determine the impact of customer satisfaction, affective commitment, trust, perceived value, and service quality on customer engagement.	
Main finding 25	The overall mean scores for respondents' engagement with their open medical aid provider is above the mid-point level, which indicates that respondents demonstrate some form of engagement with their open medical aid provider.
Main finding 26	The overall mean scores for respondents' value perceptions of their open medical aid provider are just below the mid-point level, which shows that respondents perceived open medical aid provider services as somewhat valuable.
Main finding 27	The overall mean scores for respondents' service quality perceptions of their open medical aid provider are above the mid-point level, which shows that respondents' expectations are being fulfilled by their open medical aid provider.
Secondary objective 8: Determine the impact of customer satisfaction, affective commitment, trust, perceived value, and service quality on customer engagement.	
Main finding 28	Customer satisfaction has a positive and significant impact on customer engagement.
Main finding 29	Trust has a positive and significant impact on customer engagement.
Main finding 30	Affective commitment has a positive and significant impact on customer engagement.
Main finding 31	Perceived value has a positive and significant impact on customer engagement.
Main finding 32	Service quality has a positive and significant impact on customer engagement.

5.7 Conclusion

In Chapter 5, the literature review findings were presented and interpreted. The sample realisation rate was presented. The literature review findings obtained with reference to respondents' customer satisfaction, affective commitment, trust, customer engagement, perceived value, and service quality dimensions (i.e. reliability, responsiveness, assurance, and empathy) followed. In addition, the statistical results were reported, including the frequencies, percentages, means and standard deviations, Cronbach's alpha coefficients, content and construct validity and the overall mean scores.

Furthermore, a standard multiple regression analysis was conducted in order to compare the proposed theoretical framework and to test the hypotheses formulated. The chapter then concluded with a summary of all the main findings according to each secondary objective.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

Chapter 6 concludes this study by providing conclusions and recommendations pertaining to the results on the predictors of customer engagement in the South African open medical aid industry. The conclusions presented in this chapter were derived from the main findings that were examined in Chapter 5, as well as the findings from the literature reviews conducted in Chapters 1, 2 and 3, which led to this study's framework conceptualisation.

The chapter commences with a summary of the research problem. Subsequently, the conclusions, implications, and recommendations are presented for each of the secondary objectives. Furthermore, a table is provided that illustrates the connection between the research objectives, the literature review, the sections of the questionnaire, the hypotheses, the main findings, and the conclusions and recommendations of the study. The chapter concludes with an indication of the limitations of the study, and recommendations for future research.

6.2 Overview of the study

As discussed in Chapter 1 (see section 1.3.3), competition among the South African open medical aid providers are high as opposed to restricted medical aid providers as they do not have the guarantee of certain employees, industry organisations or unions to provide them with customers (SA Medical Aids, 2018). South Africa's open medical aid industry is dominated by five major open medical aid providers, namely Bonitas, Discovery, Fedhealth, Medshield, and Momentum. Discovery dominates the open medical aid industry by serving almost a million more customers than the remaining four open medical aid providers (Discovery, 2019a; Erasmus, 2016c; Fin24, 2017). Subsequently, South Africa's open medical aid providers are facing several challenges due to new regulations, effects of mergers and amalgamations, as well as the changing expectations of customers (PwC, 2017; Selfmed Medical Scheme, 2017).

Furthermore, the open medical aid industry is challenged with the effortlessness with which customers can merely switch from one open medical aid to another when they are dissatisfied (Gull & Iftikhar, 2012:254; Selfmed Medical Scheme, 2017). Therefore, as explained in section 1.3.3, it is important for open medical aid providers to build strong

relationships with their current customers in order to remain competitive and to prevent them from leaving and joining another open medical aid provider (Qasim & Asadullah, 2012:6).

To address this research problem, the primary objective of this study was to determine the predictors of customer engagement in the South African open medical aid industry (refer to Chapter 1, section 1.5). In addition, eight secondary objectives were formulated to support and ultimately achieve the study's primary objective (see section 1.5).

The next section focuses on the main findings obtained from both the theoretical examinations with the aim of providing a better understanding of the connections between the selected constructs and customer engagement. For each secondary objective, calculated recommendations are offered to provide direction to open medical aid providers for enabling customer engagement among current and prospective customers of their open medical aid services.

6.3 Conclusions and recommendations

This section presents conclusions that were drawn based on the theoretical background (Chapters 2 and 3) and the empirical results (Chapter 5). The primary objective of the study was to determine the predictors of customer engagement in the South African open medical aid industry. Eight secondary objectives have been formulated for this study and are subsequently addressed by stating the associated conclusions.

6.3.1 Secondary objective 1

Secondary objective 1: Develop a sample profile of existing open medical aid customers who participated in the study.

Section A of the questionnaire gathered the sample profile to address secondary objective 1. This section assessed respondents' year of birth, gender, level of education, employment status, type of medical cover, and cost of medical aid.

The main findings regarding the sample profile obtained from this study's sample were presented in Chapter 5, section 5.3 (main findings 1 to 3), and are provided again below:

- The majority of the respondents were females, between the ages 29 and 38 years, with a technical/university diploma education and employed full-time.
- The majority (37.54%) of respondents have comprehensive medical cover.
- The majority (36.49%) of respondents consider their medical aid as relatively expensive.

Based on main findings 1, 2, and 3 from section 5.3, the following conclusion and recommendation can be noted pertaining to secondary objective 1:

- **Conclusion 1**

  As indicated, more females participated in the study than males and are between the ages of 29 and 38 years. Furthermore, most respondents have a university/technical diploma education and employed full-time. The most popular type of medical cover was a comprehensive plan. Lastly, most respondents rated the cost of their medical aid is expensive.

- **Recommendation 1**

  Open medical aid providers should develop a consistent representation of the target population in terms of gender and age groups, which can provide them with valuable and significant information for market segmentation purposes. By doing this, open medical aid providers may find important differences in terms of their customers' needs, wants and behaviour, that can be used to tailor specific marketing communication and packages for different customers. This will definitely result in higher customer satisfaction as open medical aid providers will understand the needs of their different markets better, and make better-informed marketing decisions. Further research can also be conducted to determine possible reasons why more females are the main or primary member than males. It is important for open medical aid providers to understand what exactly attract customers to these medical aid services and to determine what would encourage customers to convince other prospective customers to apply for membership. Moreover, it might be useful for open medical aid providers to investigate why a comprehensive

plan is the most popular type of medical cover and why most respondents rated the cost of their medical aid is expensive.

6.3.2 Secondary objective 2

Secondary objective 2: Determine respondents' satisfaction with their open medical aid provider.

In Chapter 2 (section 2.5.3), the literature review highlighted that customer satisfaction can be defined as a measurement of how well a business' product or service meets or exceeds the customer's expectations (Armstrong *et al*., 2012:584; De Meyer-Heydenrych *et al*., 2017:412; Ranabhat, 2018:9). For example, customers' satisfaction may increase as open medical aid providers meet or exceed customers' expectations. Furthermore, customer satisfaction is also referred to as a state that customers experience when they are happy with the service delivery of a business (Andersson & Liedman, 2013:1).

The following main findings regarding customer satisfaction resulted from the literature review:

- Customer satisfaction occurs when a business succeeds in fulfilling their customers' expectations.
- Satisfied customers will likely continue to repeatedly purchase a product or service, and recommend the product or service to others.
- Customer satisfaction is a necessity for the survival of any business in the long-term.
- Hong *et al*. (2019:3) note that businesses can identify their position in a competitive market, recognise the factors leading to customer dissatisfaction, as well as introduce countermeasures accordingly by contrasting their level of customer satisfaction with those of other businesses.
- In the context of this study, customer satisfaction refers to the willingness among customers to choose the same open medical aid provider repeatedly.

Thus, based on main findings 4 and 5 (from section 5.3), the following conclusion and recommendation can be noted pertaining to secondary objective 2:

- **Conclusion 2**

  The respondents were of the opinion that they are pleased with their open medical aid providers' services and that it was a good decision to choose their open medical aid provider. Nevertheless, some uncertainty was portrayed as respondents indicated that their decision to get coverage with their current open medical aid provider was not a wise one. This can be due to uninformed decisions and a lack of research regarding whether the current medical aid provider is still the best option. Consumers tend to just assume that they only have to pick a medical aid provider once and not to search for better medical aid options after a period of time.

- **Recommendation 2**

  Open medical aid providers aiming to satisfy their customers should focus on providing excellent service and good value for money. Furthermore, open medical aid providers should measure customer satisfaction continuously. This can be done by using online surveys, for example, where customers can provide their feedback by stating their complaints or compliments. Open medical aid providers can identify factors that lead to dissatisfied customers and introduce countermeasures accordingly by comparing their level of customer satisfaction with those of other open medical aid providers (Hong *et al*., 2019:30). Open medical aid providers can use the results of the survey to indicate what they should reinforce and identify areas that require improvement. It is important for open medical aid providers to invest in communication to ensure that customers are fully aware and understand the terms and conditions of their medical policy. Moreover, open medical aid providers should investigate the possible reasons why their existing members consider their services as satisfactory and to build on these reasons to remain competitive and prevent customers from leaving.

6.3.3 Secondary objective 3

Secondary objective 3: Determine respondents' affective commitment towards their open medical aid provider.

The literature review regarding commitment in Chapter 3 (see section 3.3.2) revealed that commitment reflects a customer's feeling of attachment with, and intention to continue a relationship with a business (Joseph, 2012:123; Morgan & Hunt, 1994b:23; Rahmani-Nejad

et al., 2014:264). Commitment is grounded in the relationship marketing theory and is regarded as one of the fundamental factors of relationship quality (De Ruyter *et al*. 2001:281; Morgan & Hunt, 1994b:22; Mukherjee & Nath, 2007:1192; Wilson, 1995:8). Section 2.4.1, indicates that relationship marketing is based on all the marketing activities used to attract, maintain, and develop customer relationships (Berry, 1983:25; Morgan & Hunt, 1994a:34). Regarding relationship quality, section 3.3.2, shows that relationship quality is based on the customer's complete evaluation of the relationship with a business (Henning-Thurau & Klee, 1997:751; Palmatier *et al*., 2006:138); Reynolds *et al*., 2014:31; Vize *et al*., 2017:2).

As explained in section 3.3.2.1, three types of commitment exist, namely affective-, normative- and continuance commitment. For this study, affective commitment was selected for further investigation. Affective commitment arises when customers continue a relationship with a business because they want to (Meyer & Allen, 1991:67). Affective commitment can provide insights into customers' emotional attachments to a business based on their feelings toward the business (Gruen *et al*., 2000:37).

The following main findings of affective commitment can be derived from the literature review:

- Commitment is grounded in the relationship marketing theory and is regarded as a fundamental factor of relationship quality.
- Relationship marketing involves establishing strong, long-term customer relationships, whereas relationship quality involves the customer's complete evaluation of the relationship with a business.
- Commitment represents the highest stage of personal connection (Ćulibrk *et al*., 2018:2; Terblanche, 2008:71)
- Affective commitment is regarded as the main principle of organisational commitment.
- Affective commitment could lead to a customer's tendency to engage with a business.
- Within the context of this study, affective commitment reveals that customers remain with their open medical aid provider because they want to.

Consequently, based on the main findings 6 and 7 from section 5.3, the following conclusion and recommendation are provided pertaining to secondary objective 3:

- **Conclusion 3**

  Most respondents displayed commitment towards their open medical aid providers' services as they agreed that they consider themselves loyal to their open medical aid providers. However, some doubt was shown since respondents indicated that they least agreed with that they want to remain a customer of their open medical aid provider because they feel a strong sense of belonging towards it.

- **Recommendation 3**

  Open medical aid providers can conduct an in-depth investigation into the statements measuring affective commitment in this study. Furthermore, open medical aid providers could also focus on maintaining affective commitment by providing excellent services to customers (Davijani *et al*., 2015:114). Open medical aid providers can also focus on maintaining the affective commitment by implementing reward or loyalty programmes, where customers can earn points by, for example, being more active (i.e. more visits to the gym, attaining certain exercising classes). Customers who earn a certain amount of points could be rewarded with several discounts, such as nutritional discount (i.e. Woolworth's food), discounted gym memberships, to name a few. These programmes can encourage customers to live more energetic and healthier lives. Employees of open medical aid providers should display true interest in customers' wellbeing, which can develop a more personal connection. To conclude, open medical aid providers should focus on developing relationships with customers in order to increase and maintain their loyalty.

6.3.4 Secondary objective 4

Secondary objective 4: Determine respondents' trust in their open medical aid provider.

In Chapter 3 (section 3.3.1.1), it was established that trust entails a customer's confidence in the quality, and reliability of the services offered by a business (Garbarino & Johnson, 1999:73; Morgan & Hunt, 1994b:23; Rahmani-Nejad *et al*., 2014:263). Therefore, similar to

commitment, trust is also grounded in the relationship marketing theory and is considered a fundamental relationship quality factor (De Ruyter *et al*. 2001:281; Morgan & Hunt, 1994b:22; Mukherjee & Nath, 2007:1192; Wilson, 1995:8). Section 3.3.1.1 explained that trust is a multidimensional construct, which consists of competence, benevolence, and integrity trust (Aurifeille & Medlin, 2009:9; Clark *et al*., 2010:232; Mayer *et al*., 1995:717; Roy *et al*., 2011:98; Xie & Peng, 2009:574). For the purpose of this study, trust was measured as an overall construct.

According to Persaud and Bonham (2018:26) and Sakallaris *et al*. (2016:54), customer-business relationships are built on trust. Trust will increase a customer's willingness to disclose personal information, comply with procedures, and encourage customers to be more involved with the business (Persaud & Bonham, 2018:26). For example, customers who trust their open medical aid providers will likely be more willing to disclose their medical information to open medical aid providers.

The following main findings pertaining to trust resulted from the literature review:

- Similar to commitment, trust is also grounded in the relationship marketing theory and is regarded as a fundamental factor of relationship quality.
- Within the context of this study, trust refers to a customer's (the trustor's) overall belief that the open medical aid provider (the trustee) can be relied on to execute a particular service according to the customer's needs.

Accordingly, based on the main findings 8 and 9 from section 5.3, the following conclusion and recommendation can be noted pertaining to secondary objective 4:

- **Conclusion 4**

  The majority of respondents were of the opinion that they trust their open medical aid providers' services. Yet, some uncertainty is indicated as respondents specified that they least agreed with the statement that their open medical aid providers offer them a feeling of trust.

- **Recommendation 4**

  In order to create perceptions of increased trustworthy service delivery, open medical aid providers must further explore the reasons why customers think their services are

trustworthy and then build on these characteristics to strengthen their position among customers. Open medical aid providers should encourage customer feedback that will enable them to gain a better understanding of whether customers are satisfied with their overall experience. Furthermore, open medical aid providers should provide excellent customer service by training their employees to provide adequate information to customers and ensure that their services are of the highest standards, without any errors. Additionally, by fulfilling their promises, open medical aid providers could ultimately improve customer trust.

6.3.5 Secondary objective 5

Secondary objective 5: Determine respondents' engagement with their open medical aid provider.

In Chapter 3 (section 3.4), a comprehensive theoretical overview of customer engagement was provided in order to better conceptualise the construct. In section 3.4.1, various definitions of customer engagement were provided, which were adapted from previous studies. From these definitions, several universal elements have been identified and were summarised in Table 3-1.

Chapter 3 further focused on discussing the importance of customer engagement (see section 0). During this discussion, several factors were presented that highlighted the necessity of customer engagement. Furthermore, the elements of customer engagement were discussed (see section 3.4.3), followed by a discussion and illustration of the various levels of engaged customers (see section 3.4.4). The chapter concluded with discussions (in sections 3.4.5) the various predictors of customer engagement. The predictors of customer engagement consisted of customer interaction, brand commitment, customer commitment (calculative and affective), customer satisfaction, customer involvement, trust, perceived value, and service quality. However, for the purpose of this study, customer satisfaction, trust, affective commitment, perceived value, and service quality were incorporated in the questionnaire as predictors of customer engagement in the South African open medical aid industry. These constructs were selected based on their relevance within the South African open medical aid industry.

Consequently, based on the main findings 10 and 11 from section 5.3, the following conclusion and recommendation are provided pertaining to secondary objective 5:

- **Conclusion 5**

  Most respondents displayed engagement with their open medical aid provider since they consider their open medical aid providers to be reliable. Nonetheless, uncertainty was illustrated as respondents stated that they least agreed with the statement that they frequently participate in the activities of their open medical aid providers.

- **Recommendation 5**

  Open medical aid providers should encourage their customers to take part in the activities of the open medical aid provider, such as competitions or fundraisers. Open medical aid providers can encourage customer participation by rewarding customers with loyalty points (as mentioned in section 6.4.3) for participating in these competitions or fundraisers. Customers should be made aware of these activities and events via email or other methods of communication as preferred by customers. By increasing the participation of customers, open medical aid providers could improve customer engagement. Furthermore, it is important for open medical aid providers to understand what their customers want, and to act on their requirements, where possible.

6.3.6 Secondary objective 6

Secondary objective 6: Determine respondents' value perceptions of their open medical aid provider.

In Chapter 2 (section 2.7.2), different definitions of perceived value were presented. The most commonly used definition is supplied by Zeithaml (1988:14), who defines perceived value as the complete evaluation of the product or service's convenience based on the customer's perception of what was received and what was given. As discussed in section 2.7.2, customers are becoming more demanding, therefore it is imperative for open medical aid providers to understand what customers value in order to remain competitive (El-Adly & Eid, 2015:2; Lamb *et al*., 2015:46).

The following main findings regarding perceived value resulted from the literature review:

- Different definitions of perceived value exist. Resemblances noted from these definitions are that perceived value is the interpretation of what the customers receive with what

they provide. What the customer receives can be a service or a benefit, and what they provide is considered a cost or a sacrifice (Suryadi *et al*., 2018:3).

- Several definitions of perceived value exist.
- The perceived value definition presented by Zeithaml (1988:14) was chosen for this study.
- Perceived value is an important measure for achieving a competitive advantage.
- Perceived value can be improved by creating and providing excellent service experiences (Morar, 2013:169).

Based on the main findings 12 and 13 from section 5.3, the following conclusions and recommendation can be noted pertaining to secondary objective 6:

- **Conclusion 6**

  Respondents were of the opinion that their open medical aid providers' product and service offerings are sufficient to meet their needs. However, some doubt was shown as most respondents indicated that they agreed the least with the statement that the prices of their open medical aid providers are low compared to other open medical aid providers.

- **Recommendation 6**

  It would be wise for open medical aid providers to stay up to date with the most recent medical developments and with the developments of their competitors. Perceived value can be increased by open medical providers by creating and providing customers with excellent service experiences (Morar, 2013:169). Furthermore, open medical aid providers should continuously improve or adjust their service offerings to meet customers' expectations, which will also help them to remain competitive.

6.3.7 Secondary objective 7

Secondary objective 7: Determine respondents' service quality perceptions of their open medical aid provider.

The literature review regarding service quality in Chapter 2 (see section 2.5.1) revealed that the SERVQUAL model, developed by Parasuraman *et al*. (1985:41), is the most extensive and effective scale for measuring service quality. According to Cronin and Taylor (1992:56), service quality results from the comparison of the customer's service expectations with the performance of the business. As discussed in section 2.7.2.1, the SERVQUAL measure originally consisted of ten dimensions but were later reduced to five dimensions due to the overlapping of some dimensions (Daniel & Berinyuy, 2010:10; Marić *et al*., 2016:13; Parasuraman *et al*., 1985:47). These five dimensions are tangibles, reliability, responsiveness, assurance, and empathy (Daniel & Berinyuy, 2010:10; Marić *et al*., 2016:13). However, as explained in Chapter 1 (section 1.4.7), services are intangible, and can therefore not be seen or touched (Mosadeghrad, 2014:78; Siami & Gorji, 2012:1957). As a result, this study only focused on the four most relevant dimensions to this industry, namely reliability, responsiveness, assurance, and empathy.

The following main findings of service quality can be derived from the literature review:

- Service quality is measured by using the SERVQUAL measure.
- The SERVQUAL measure consists of five dimensions, namely tangibles, reliability, responsiveness, assurance, and empathy.
- Pertaining to open medical aid providers, *reliability* refers to the ability of open medical aid providers to handle customer complaints, performing services right the first time, maintaining error-free records of customers' medical history, and keeping fees and other charges as consistent as possible.
- Within the context of this study, *responsiveness* reflects the ability and willingness of the open medical aid provider's employees to help customers, provide the service at the given time, avoid long waiting time of customers to receive the service, get an appointment at the given time by the customer, have convenient operating hours, and availability in case of emergencies.
- In the context of this study, *assurance* is seen as the honesty and friendly support of the open medical aid provider's employees, and their ability to inspire trust and confidence handle problems and maintain the confidentiality of customers' medical information.

- Pertaining to open medical aid providers, *empathy* refers to the ability of open medical aid providers to understand customers' needs, respond to customers' questions and concerns, and provide personalised attention.

Consequently, based on the main findings 14 and 15 from section 5.3, the following conclusion and recommendation can be derived pertaining to secondary objective 7:

- **Conclusion 7**

  Respondents were of the opinion that their open medical aid providers deliver quality services as they mostly agreed that their open medical aid provider has convenient consulting hours. Yet, doubt was shown as respondents' least agreed with that their open medical aid provider offers them individual attention and have their best interest at heart.

- **Recommendation 7**

  The call centres of open medical aid providers must be monitored and evaluated on a regular basis. The employees of open medical aid providers must be trained to assist customers and provide adequate information, such as type of medical cover (e.g. hospital plan or medical aid), contributions, or benefit options whenever required. In addition, open medical aid providers could develop customer profiles, which can contribute to personalising the service. Furthermore, open medical aid providers must provide customers with several options from which they can choose. For example, the decision between selected hospital plans or selected comprehensive medical aids. These hospital plans or medical aids should be customised according to the medical needs of individual customers with reference to their monthly income.

6.3.8 Secondary objective 8

Secondary objective 8: Determine the impact of customer satisfaction, affective commitment, trust, perceived value, and service quality on customer engagement.

Insight was obtained (in section 1.4.8 and Chapters 2 and 3) from the detailed literature review, which indicated that connections exist between the selected constructs, namely

customer satisfaction, affective commitment, trust, customer engagement, perceived value, and service quality.

The results of the standard multiple regression analysis completed in Chapter 5 (see section 5.6) determined that 82% of the variance found in respondents' engagement towards their open medical aid providers can be explained by customer satisfaction, trust, affective commitment, perceived value, and service quality. The standard multiple regression analysis further indicated the following:

- Customer satisfaction does not have a positive and significant impact on customer engagement.
- Trust has a positive and significant impact on customer engagement.
- Affective commitment has a positive and significant impact on customer engagement.
- Perceived value has a positive and significant impact on customer engagement.
- Service quality has a positive and significant impact on customer engagement.

Along with the main findings that resulted from the multiple regression analysis, important main findings from the empirical investigation were also determined (main findings 16 to 32) which relate to secondary objective 8. Therefore, based on the main findings of the literature review, the following main conclusion and recommendation were identified:

- **Conclusion 8**

  There is a positive and significant impact on the relationships between all of the selected constructs, except for the relationship between customer satisfaction and customer engagement.

- **Recommendation 8**

  The regression results (see Table 5-17) showed that service quality has the strongest positive significant impact on customer engagement ($\beta = 0.410$; S.E. = 0.053; p-value = 0.000), followed by trust ($\beta = 0.285$; S.E. = 0.049; p-value = 0.000). Affective commitment and perceived value also displayed a positive significant impact on customer engagement. In order for open medical aid providers to encourage customer

engagement with open medical aid providers, these open medical aid providers should improve interactions with customers, provide excellent service quality, and establish strong relationships with customers. This can be done by interacting with customers on a regular basis and asking for customer feedback after a service have been provided. Open medical aid providers can focus on maintaining customer relationships by showing appreciation through, for example, giving away branded (logo of open medical aid provider) items, such as a basic first aid kit or pill holders. Additionally, open medical aid providers can encourage customer engagement by exceeding customers' expectations. For example, open medical aid providers can deliver services faster than expected. This can be achieved by the strategies recommended in sections 6.3.1 and 6.3.7.

6.4 Connections between the research objectives, literature, questionnaire sections, hypotheses, main findings, conclusions, and recommendations

The purpose of this section is to connect the formulated secondary objectives (see Chapter 1, section 1.5) to the main findings in order to conclude whether the primary objective of this study was achieved. Table 6-1 presents a summary of the connections between the research objectives, the literature, the questionnaire sections, hypotheses, main findings, conclusions, and recommendations.

Table 6-1: Summary of the connections between the research objectives, literature, questionnaire sections, hypotheses, main findings, conclusions, and recommendations

Primary objective	Secondary objective	Literature	Questionnaire section	Hypothesis	Main finding	Conclusion	Recommendation
	1		Section A		Main findings 1 to 3 (section 5.3)	Conclusion 1	Recommendation 1
	2	Chapter 2	Section B	H1	Main findings 4 and 5 (section 5.3.1)	Conclusion 2	Recommendation 2
	3	Chapter 3	Section B	H2	Main findings 8 and 9 (section 5.3.3)	Conclusion 4	Recommendation 4
	4	Chapter 3	Section B	H3	Main findings 6 and 7 (section 5.3.2)	Conclusion 3	Recommendation 3
	5	Chapter 3	Section B		Main findings 10 and 11 (section 5.3.4)	Conclusion 5	Recommendation 5
	6	Chapter 2	Section B	H4	Main findings 12 and 13 (section 5.3.5)	Conclusion 6	Recommendation 6
	7	Chapter 2	Section B	H5	Main findings 14 and 15 (section 5.3.6)	Conclusion 7	Recommendation 7
	8	Chapter 5		H1 to H5	Main findings 16 to 32 (sections 5.4 to 5.5)	Conclusion 8	Recommendation 8

Taking into consideration the information provided in Table 6-1, it can be concluded that the primary and secondary objectives formulated for this study have been met. As explained in Chapter 5 (section 5.5.1), customer satisfaction does not have a statistically significant positive impact on customer engagement.

6.5 Limitations

Although this study provided valuable information regarding predictors of customer engagement in the South African open medical aid industry, it still has limitations. According to Kent (2007:550), all studies have limitations. The theoretical, as well as empirical limitations, are presented in the following sections.

6.5.1 Limitations of the theoretical background

- A limited number of high-quality academic articles and sources of literature on the South African open medical aid industry was available.

- No research or studies, to the best of the researcher's knowledge, have been conducted to determine the connections between customer satisfaction, affective commitment, trust, perceived value, and service quality as predictors of customer engagement within the South African open medical aid industry. For that reason, the researcher mainly depended on literature that was based on other industries.

- In this study, the researcher did not focus on all three types of commitment as recognised by some scholars (Jaros, 2007:7; Meyer & Allen, 1991:67). For the purpose of this study, only the most relevant core type, namely affective commitment was investigated.

- In this study, the researcher did not focus on all five dimensions of service quality as acknowledged by several scholars (Baldwin & Sohal, 2003:208; Parasuraman *et al*., 1988:23; Yarimoglu, 2014:85). Instead, only the most relevant dimensions, namely reliability, responsiveness, assurance, and empathy were investigated.

6.5.2 Limitations of empirical research

- This study was conducted among open medical aid customers in three selected cities (i.e. Klerksdorp, Potchefstroom, and Rustenburg) located in the North West Province of South Africa. Therefore, the results and findings are not a representation of the opinions of all open medical aid customers in South Africa.

- A non-probability convenience sample was drawn, as a sampling frame of customers of open medical aid providers was not available.

Regardless of the limitations that were recognised in this study, there are a number of recommendations that can be made for future research and are presented in the next section.

6.6 Recommendations for future research

The following recommendations are made for future research:

- Future research can aim to attain a target market that is a better representation of the target sample by focusing on the opinion of all medical aid customers (both open and restricted). This study only focused on customers of open medical aid providers.

- The same study can be extended to more cities in other provinces in South Africa to allow for a more representative opinion of open medical aid customers in South Africa.

- The same study can focus on all three types of commitment (i.e. normative commitment, continuance commitment, and affective commitment). This study mainly focused on affective commitment.

- Different opinions of different demographic groups (such as ethnicity) can exist, which should be investigated further. Future research can aim to determine what racial groups make us of private healthcare services and why.

- Future research can focus on the age of customers to determine whether older customers pay more or fewer contribution fees than younger customers or vice versa, and if so, the possible reasons.

- Future studies can also aim to achieve increased population representation by means of utilising probability sampling by gaining access to medical records of customers.

6.7 Conclusion

This chapter concludes the study. Chapter 6 started with an overview of the study's research problem, followed by the main conclusions and recommendations. Subsequently, Table 6-1 summarised the identified connections between the secondary objectives, literature, hypotheses, questionnaire sections, main findings, conclusions, and recommendations. In

addition, the theoretical background and empirical research limitations were indicated. This chapter concluded with recommendations for potential future research.

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APPENDIX A: FINAL QUESTIONNAIRE

***Questionnaire number*:** | | | |

This survey forms part of a Master's study in Marketing Management at the North-West University (Potchefstroom Campus), with a specific focus on customer engagement in open medical aid providers.

Objective:

The objective of this study is to measure customer engagement in the South African open medical aid industry.

Confidentiality and anonymity:

Participating in this survey is entirely voluntary, and you may withdraw from the process when you want to do so. All information that you provide will be treated with the highest standard of privacy and will remain entirely anonymous. Additionally, the data attained from this survey will be stored in a secure site, and destroyed within the next three years. No data will be disclosed to any other parties and no data will be reported on an individual basis.

Results:

The research results will only be used empirically for the written dissertation of the study. All participants are welcome to request results upon completion of this study.

Completing the questionnaire should take approximately 10 minutes of your time. When evaluating a question, please answer from your own perspective, by marking or completing where required. Please accept my appreciations, in anticipation of your willingness to participate in this research. Please contact Ms Nel (at hanrinel94@gmail.com) for any inquiries.

Hanri Nel

Screening questions:

Are you a member of ONE of the following major South African medical aid providers?		
Bonitas Medical Fund	Yes	No
Discovery Health	Yes	No
Fedhealth	Yes	No
Medshield	Yes	No
Momentum Health	Yes	No
Are you the principal/primary member of the above medical aid provider?	Yes	No
Have you been a member of the above medical aid provider for **two years of longer**?	Yes	No

If your answer is ‘Yes’ to all of the above questions, please complete the questionnaire.

If your answer is ‘No’ to one the above questions, you do not have to complete the questionnaire.

SECTION A – BACKGROUND INFORMATION

The aim of this section of the questionnaire is for the sole purpose of developing a sample profile of the respondents.

9. In which year were you born? 19_____

10. What is your gender?

Male	1
Female	2
Prefer not to say	3

11. What is your highest level of education?

Some primary school	1
Primary school completed	2
Some high school	3
Matric / Grade 12 completed	4
Technical College diploma	5
University or Technology diploma	6
University degree (B-degree or Honours)	7
Postgraduate degree (Masters or Doctorate)	8

12. Which ONE of the following best describes your current employment status?

Student	1
Self-employed	2
Full-time employed	3
Part-time employed	4
Housewife or Househusband	5
Retired	6
Unemployed	7
Other (please specify):	8

13. What type of medical aid cover do you have with your current medical aid provider?

Savings plan	1
Hospital plan	2
Comprehensive plan	3
Other	4

14. Overall, how would you rate the cost of your current medical aid provider?

Affordable	1
Somewhat affordable	2
Neutral	3
Somewhat unaffordable	4
Unaffordable	5

SECTION B

Keeping your **current medical aid provider** in mind, please indicate your level of agreement with the following statements on a scale of 1 to 5, where 1 is '*strongly disagree*' and 5 is '*strongly agree*'.

Statement	**Strongly disagree**	**2**	**3**	**4**	**Strongly agree**
Customer satisfaction					
My decision to get medical coverage with my current medical aid provider was a wise one.	1	2	3	4	5
I feel good about my decision to get medical cover from my current medical aid provider.	1	2	3	4	5
I am pleased that I got medical cover from my current medical aid provider.	1	2	3	4	5
Overall, I am satisfied with my current medical aid provider.	1	2	3	4	5
Affective commitment					
I consider myself a loyal customer of my medical aid provider.	1	2	3	4	5
I want to remain a customer of my current medical aid provider, because I feel strongly attached to it.	1	2	3	4	5
I want to remain a customer of my current medical aid provider, because I feel a strong sense of belonging towards it.	1	2	3	4	5
Trust					
My medical aid provider offers me a feeling of trust.	1	2	3	4	5
My medical aid provider provides a trustworthy impression.	1	2	3	4	5
I have trust in my medical aid provider's service.	1	2	3	4	5
My medical aid provider can be relied upon to keep promises.	1	2	3	4	5
My medical aid provider is trustworthy.	1	2	3	4	5
I have complete confidence in my medical aid provider.	1	2	3	4	5
Customer engagement					
My medical aid provider makes me feel like I belong.	1	2	3	4	5
The employees of my medical aid provider makes me feel at home.	1	2	3	4	5
I am proud to be a customer of my medical aid provider.	1	2	3	4	5
My medical aid provider's employees inspire me.	1	2	3	4	5
I care about my medical aid provider's product and service offerings.	1	2	3	4	5
I mostly have positive service interactions with my medical aid provider.	1	2	3	4	5
My medical aid provider keeps its promises.	1	2	3	4	5
My medical aid provider is reliable.	1	2	3	4	5
My medical aid provider has integrity (acts fairly, ethically and openly).	1	2	3	4	5

I feel energised when interacting with my medical aid provider.	1	2	3	4	5
Statement	**Strongly disagree**	**2**	**3**	**4**	**Strongly agree**
I am completely involved when interacting with my medical aid provider.	1	2	3	4	5
I am willing to put effort into interacting with my medical aid provider.	1	2	3	4	5
I frequently make use of my medical aid provider's products and/or services.	1	2	3	4	5
I frequently participate in the activities of my medical aid provider (such as fund raisers, competitions, etc.)	1	2	3	4	5
Perceived value					
The price of my medical aid provider is low compared to other medical aid providers.	1	2	3	4	5
The flexibility of my medical aid provider's product and service offerings is sufficient to meet my needs.	1	2	3	4	5
My medical aid provider offers additional financial benefits and assistance.	1	2	3	4	5
I can readily understand the exclusions in the policy documents I received from my medical aid provider.	1	2	3	4	5
I regard the policy premium I pay to my medical aid provider as acceptable.	1	2	3	4	5
I consider the policy I have with my medical aid provider to be a good purchase.	1	2	3	4	5
Service quality					
Reliability					
When my medical aid provider promises to do something by a certain time, it does so.	1	2	3	4	5
When I have a problem, my medical aid provider shows a sincere interest in solving it.	1	2	3	4	5
My medical aid provider performs its services right the first time.	1	2	3	4	5
My medical aid provider offers its services at the time it promises to do so.	1	2	3	4	5
My medical aid provider keeps error-free records.	1	2	3	4	5
I consider the policy I have with my medical aid provider to be a good purchase.	1	2	3	4	5
Responsiveness					
The employees of my medical aid provider tell me exactly when services will be performed.	1	2	3	4	5
The employees of my medical aid provider delivers prompt services.	1	2	3	4	5
The employees of my medical aid provider are always willing to help me.	1	2	3	4	5
The employees of my medical aid provider are never too busy to respond to my requests.	1	2	3	4	5

Statement	Strongly disagree	2	3	4	Strongly agree
Assurance					
My medical aid provider's employees instil confidence in its customers.	1	2	3	4	5
I feel safe in my transactions with my medical aid provider.	1	2	3	4	5
The employees of my medical aid provider are consistently courteous towards me.	1	2	3	4	5
The employees of my medical aid provider have the necessary knowledge to answer my questions.	1	2	3	4	5
Empathy					
My medical aid provider offers me individual attention.	1	2	3	4	5
My medical aid provider has convenient consulting hours.	1	2	3	4	5
The employees of my medical aid provider offers me personal attention.	1	2	3	4	5
My medical aid provider has my best interests at heart.	1	2	3	4	5
The employees of my medical aid provider understand my specific needs.	1	2	3	4	5

Thank you for taking the time to complete this survey!

APPENDIX B: LANGUAGE EDITING CONFIRMATION

Cecile van Zyl
Cell: 072 389 3450
Email: Cecile.vanZyl@nwu.ac.za

19 September 2019

To whom it may concern

Language editing and translation

Dear Mr / Ms

Re: Language editing of master's dissertation: Predictors of customer engagement in the South African open medical aid industry

I hereby declare that I language edited the abovementioned master's dissertation by Ms Hanri Nel (student number: 24157244).

Please feel free to contact me should you have any enquiries.

Kind regards

Cecile van Zyl
Language practitioner
BA (PU for CHE); BA honours (NWU); MA (NWU)
SATI number: 1002391

APPENDIX C: PROOF OF ETHICAL CLEARANCE

Private Bag X6001, Potchefstroom,
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Research Ethics Regulatory Committee

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Email : Ethics@nwu.ac.za

ETHICAL CLEARANCE LETTER OF STUDY

Based on the approval by the **Economic and Management Sciences Research Ethics Committee (EMS-REC) on 31/05/2018** after being reviewed at the meeting held on **18/05/2018**, the North-West University Research Ethics Regulatory Committee (NWU-RERC) hereby **approves** your project as indicated below. This implies that the NWU-RERC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: Antecedents of customer engagement in the South African open medical aid industry.

Project Leader/Supervisor: Dr N Mackay
Student: H Nel

Ethics number: N W U - 0 0 3 0 7 - 1 8 - A 4
(Institution / Project Number / Year / Status)

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Application Type:

Commencement date: 2018-05-18 **Expiry date**: 2021-05-17 **Risk:** Low risk

Special conditions of the approval (if applicable):

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- *The project leader (principle investigator) must report in the prescribed format to the NWU-RERC via EMS-REC:*
  - *annually (or as otherwise requested) on the progress of the project, and upon completion of the project*
  - *without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.*
  - *Annually a number of projects may be randomly selected for an external audit.*
- *The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the EMS-REC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.*
- *The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-RERC via EMS-REC and new approval received before or on the expiry date.*
- *In the interest of ethical responsibility the NWU-RERC and EMS-REC retains the right to:*
  - *request access to any information or data at any time during the course or after completion of the project;*
  - *to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.*
  - *withdraw or postpone approval if:*
    - *any unethical principles or practices of the project are revealed or suspected,*
    - *it becomes apparent that any relevant information was withheld from the EMS-REC or that information has been false or misrepresented,*
    - *the required annual report and reporting of adverse events was not done timely and accurately,*
    - *new institutional rules, national legislation or international conventions deem it necessary.*

The RERC would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the RERC or EMS-REC for any further enquiries or requests for assistance.

Yours sincerely

Prof Bennie Linde
Chair NWU Economic and Management Sciences Research Ethics Committee

APPENDIX D: PROOF OF STATISTICAL ANALYSIS

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Web: http://www.nwu.ac.za

Statistical Consultation Services

Tel: +27 18 285 2016
Fax: +27 0 87 231 5294

Email: suria.ellis@nwu.ac.za

21 November 2019

Re: Dissertation, Ms H Nel, student number 24157244

We hereby confirm that the Statistical Consultation Services of the North-West University analysed the quantitative data of the above-mentioned student and assisted with the interpretation of the results. However, any opinion, findings or recommendations contained in this document are those of the author, and the Statistical Consultation Services of the NWU (Potchefstroom Campus) do not accept responsibility for the statistical correctness of the data reported.

Kind regards

Prof SM Ellis (Pr. Sci. Nat.)

Associate Professor: Statistical Consultation Services

APPENDIX E: PROOF OF TECHNICAL EDITING

Excellentia Edit & Transcribe

Physical address:
72 Eland Street
Miederpark
Potchefstroom
2531
Contact:
Email: excellentia.edit.transcribe@gmail.com
Phone: 0834755363

22 November 2019

TO WHOM IT MAY CONCERN

I hereby declare that the dissertation titled:

Predictors of customer engagement in the South African open medical aid industry

by

H Nel

24157244

has been technically edited by myself, which includes all tables and figures as well as the layout of the document's contents.

E Oosthuizen

November 2019