Australasian Marketing Journal 22 (2014) 257–267

Contents lists available at ScienceDirect

Australasian Marketing Journal

journal homepage: www.elsevier.com/locate/amj

Just what the doctor ordered? Investigating the impact of health service quality on consumer misbehaviour

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ARTICLE INFO

Article history:
Available online 26 September 2014

Keywords:
Consumer misbehaviour
Service quality
Anger
Perceived justice
Health care
Experimental design

ABSTRACT

The growth in demand and expenditure currently being experienced in the Australian health sector is also accompanied by a rise in dysfunctional customer behaviour, such as verbal abuse and physical violence, perpetrated against health service providers. While service failure and poor recovery are known to trigger consumer misbehaviour, this study investigates whether lower than expected perceived service quality generates cognitive and emotional appraisals that trigger two common forms of misbehaviour: refusal to participate and verbal abuse. Data were collected using a 2 × 2 between-subjects experiment administered via online written survey and analysed using path modelling. The findings indicate that perceptions of service encounter quality have an indirect effect on whether consumers refuse to participate in the service and/or verbally abuse the service provider through the mediating effect of anger.

CHINESE ABSTRACT

目前，澳大利亚医疗行业的需求和开支都处于不断增长中，随之而来的也有不良的消费者行为，比如针对医疗服务提供商的言语攻击和身体暴力。众所周知，医疗服务的失败和患者康复不佳都可触发消费者的不良行为。因此，本文探讨低于预期值的医疗服务质量是否会产生相应的认知和情感评价，从而触发两类常见的不良行为，即拒绝合作和言语攻击。本文通过网上书面问卷调查，以2 × 2受访者组间方式采集数据，采用路径模型分析数据。研究结果表明，对医疗服务质量的认知，和消费者是否会通过愤怒等方式拒绝配合和/或言语攻击医疗服务提供商之间没有直接关系。

1. Introduction

Health services in Australia represent 9.5% of GDP and expenditure has grown from $82.9 billion in 2001 to $140.2 billion in 2012 (Australian Institute of Health and Welfare, 2013). The growth in demand and expenditure being experienced in this sector, however, has been accompanied by a rise in consumer misbehaviour (Dyett, 2013). This rise has alarmed policymakers to the extent that it has sparked a national survey by the Australian National Preventative Health Agency (Dyett, 2013) in order to quantify the problem.

Extant research suggests that consumer misbehaviour is a significant source of role stress and emotional labour (Ben-Zur and Yagil, 2005). Burnout across a range of service industries is increasing due to the prevalence of disproportionate customer expectations, verbal aggression, and ambiguous customer expectations (Dormann and Zapf, 2004). Health care providers in particular experience a slew of negative outcomes – lower affective commitment, higher intentions to withdraw, poorer interpersonal job performance, greater neglect, and more cognitive difficulties – when exposed to patient violence and sexual harassment (Barling et al., 2001). Given the importance of this sector to the Australian economy and the growing demand for health due to an ageing population, understanding how to mitigate and manage consumer misbehaviour in health care services is critical to create a sustainable service model.

While consumer misbehaviour is often investigated following service failure and recovery (e.g., Grégoire and Fisher, 2006; Keeffe et al., 2008; McColl-Kennedy et al., 2009), there is a paucity of research that investigates whether lower than expected perceived service quality is capable of generating cognitive and emotional appraisals that trigger misbehaviour. This research gap presents an important line of inquiry because the service quality perceptions of consumers and service providers might not always align. In the absence of service failure, service

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http://dx.doi.org/10.1016/j.ausmj.2014.08.010
1441-3582/

employees may perceive that appropriate service quality was delivered, while consumers may appraise the same service encounter as lacking and thus respond with misbehaviour.

To address this gap, we investigate how perceived service quality influences consumers' emotional, cognitive, and behavioural responses to the health services. We use social exchange theory (Blau, 1964) as a theoretical framework to propose that technical and interpersonal quality will influence consumers' cognitive and affective appraisals of the service encounter, which may in turn trigger misbehaviour. More specifically, we investigate the likelihood that consumers would refuse to participate in a service or verbally abuse a service provider, as these are the two most commonly observed forms of misbehaviour in health services (Keeffe, 2010). By investigating consumer misbehaviour within high credence professional services such as health care, this research answers Harris and Reynolds' (2004) call for further study on consumer misbehaviour in different service environments.

2. Literature review

2.1. Consumer misbehaviour in service encounters

Since the inception of the marketing discipline, exchange has been a focal concept (Houston and Gassenheimer, 1987). Exchange was initially conceptualised from a purely economic, transactional standpoint: the benefits and obligations of an interaction were explicit and contractually enforceable (Blau, 1964). The rise of the service economy, however, has led marketers to consider the social aspects of exchange (Vargo and Lusch, 2004, 2008). Social exchange is predicated on the understanding that both parties need to behave in a mutually beneficial and complementary manner for their individual goals to be achieved (Blau, 1964; Cropanzano and Mitchell, 2005).

Conceptualising service encounter behaviour as mutually beneficial and complementary, however, implies that both the consumer and the service provider will behave in a functional manner (Fullerton and Punj, 1993; Harris and Ogbonna, 2002). In practice, service roles have 'a unique, and distressing, feature' (Ben-Zur and Yagil, 2005, p. 81): service providers are held to a higher behavioural standard than their consumers. While service providers are compelled to exhibit appropriate interpersonal behaviour towards consumers by virtue of their employment, consumers have no such formal behavioural obligations (Ben-Zur and Yagil, 2005; Namasivayam, 2003). These asymmetrical behavioural expectations give rise to a new concern for marketers: consumer misbehaviour.

Consumer misbehaviour is defined as 'behavioural acts by consumers, which violate the generally accepted norms of conduct in consumption situations, and thus disrupt the consumption order' (Fullerton and Punj, 2004, p. 1239; Moschis and Cox, 1989). This definition includes acts that are performed unintentionally, out of ignorance of norms, and in response to the deviant behaviour of others in the servicescape. Consumer misbehaviour has previously been referred to as deviant customer behaviour (Moschis and Cox, 1989), aberrant customer behaviour (Fullerton and Punj, 1993), opportunistic behaviour (Gruen, 1995), dysfunctional customer behaviour (Harris and Reynolds, 2003), badness behaviour (Yi and Gong, 2006), and customer rage (McColl-Kennedy et al., 2009), which is perpetrated by problem customers (Bitner et al., 1994), jaycustomers (Lovelock, 1994), and customers from hell (Zemke and Anderson, 1990). Regardless of label, the disruptive nature of this behaviour is problematic because it obstructs the co-creation of value.

Since its emergence as a field of interest in the 1990s, extant research has identified a broad range of consumer misbehaviour that flouts the expectations of exchange. Initial investigations of misbehaviour focused on identifying how consumers inappropriately acquire goods using methods such as counterfeiting (e.g., Albers-Miller, 1999), fraud (e.g., Wilkes, 1978), or theft (e.g., Cox et al., 1990). In contrast, more recent research focuses on identifying how consumers misbehave interpersonally. Such misbehaviour includes retaliation (e.g., Funches et al., 2009; Grégoire and Fisher, 2006, 2007), lying (e.g., Mazar, Amir, & Ariely, 2008), rage (e.g., Grove et al., 2012; McColl-Kennedy et al., 2009; Patterson, McColl-Kennedy, Smith, & Lu, 2009; Surachartkumtonkun, Patterson, & McColl-Kennedy, 2013), and verbal and physical abuse (e.g., Rafaeli et al., 2012). Interpersonal misbehaviour is typically psychologically harmful to the service provider, which has flow-on effects to the service organisation due to burnout, absenteeism, and turnover.

The research examines two forms of interpersonal consumer misbehaviour: refusal to participate and verbal abuse. The first behaviour, refusal to participate, refers to the behaviour of consumers who actively choose not to contribute actions or resources to a service encounter but still expect a successful outcome (Keeffe, 2010). Essentially, these consumers refuse to fully participate in co-creating the service. Refusal to participate is not yet a well-understood form of consumer misbehaviour; however, qualitative research suggests that it is particularly salient in health services because consumers contribute to the technical and functional quality of the service encounter (Keeffe, 2010; Kelley, Donnelly, & Skinner, 1990). The second behaviour, verbal abuse, is defined as the misuse of words and encompasses overt oral and/or written communication that impeded service encounters (Keeffe, 2010). Verbal abuse is the most commonly reported type of consumer misbehaviour in service encounters (Bitner et al., 1994; Harris and Reynolds, 2004; Lovelock, 2001) and is prevalent in health care (Yagil, 2008). Further, such abuse often co-occurs with refusal to participate (Keeffe, 2010).

Forms of consumer misbehaviour such as refusing to participate and verbal abuse are typically investigated as outcomes of service failure and recovery (e.g., Grégoire and Fisher, 2006; Keeffe et al., 2008; McColl-Kennedy et al., 2009). There is a paucity of research, however, that investigates whether lower than expected perceived service quality is capable of generating cognitive and emotional appraisals that can trigger these forms of misbehaviour in health care encounters.

2.2. The impact of service quality on consumer misbehaviour

Perceived service quality is one of the most salient and well-conceptualised constructs in services marketing (Brady and Cronin, 2001; Cronin and Taylor, 1992). Perceptions of service quality are generally defined as 'a consumer's judgment of, or impression about, an entity's overall excellence or superiority' (Dagger et al., 2007, p. 124). In a health service context, such perceptions result from an assessment of four service quality dimensions: interpersonal quality, technical quality, environment quality, and administrative quality (Dagger et al., 2007).

Although all four quality dimensions are critical to the overall perception of service quality, not all of the dimensions evaluate the one-to-one nature of health service encounters. For example, environment quality is an evaluation of the features of the servicescape, while administrative quality is an evaluation of the service elements that 'facilitate the production of the core service while adding value to a customer's use of a service' (Dagger et al., 2007, p. 126). However, two dimensions do evaluate the one-to-one nature of health care encounters: interpersonal quality, an evaluation of the dyadic interaction between the social actors, and technical quality, an evaluation of the 'expertise, professionalism, and competency of the service provider in delivering the service' (Dagger et al., 2007, p. 126). Consequently, this research focuses on technical and interpersonal service quality.

Consumers' evaluations of both interpersonal and technical service quality significantly influence their subsequent behaviour. For example, a low level of technical quality reduces trust in professional service providers and in turn the relationship commitment