A STUDY OF THE APPLICATION OF SDL THEORY TO THE HEALTHCARE SECTOR OF PAKISTAN

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PhD. 2022

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A thesis submitted in partial fulfillment of the requirements of Manchester Metropolitan University for the Degree of Doctor of Philosophy

Department of Operations, Technology, Events, and Hospitality Management

Manchester Metropolitan University

2022

ACKNOWLEDGEMENT

I would like to thank Allah Almighty for giving me the strength, determination, and knowledge to complete this thesis.

I would especially like to thank the DoS. of the Ph.D. studies, Dr. David Lascelles, whose constant guidance, mentorship, support, and cooperation have contributed invaluably to the completion of this study.

I would also like to thank the first supervisor in the supervisory team Dr. Oliver Kayas, for his continuous support, mentorship, and guidance throughout the program.

Moreover, I would like to thank Dr. Sofiane Tebboune, who gave me motivation and courage when I needed it the most, his guidance helped me to feel confident in myself and focus on my goals.

I would like to thank the CEOs, staff, and the associated patients of both healthcare clinics for their participation in this research work. It is due to their support, help, and cooperation that this thesis came into existence.

I would like to thank my family for supporting me throughout my Ph.D. journey. I am grateful to my mother for believing in me and praying for my well-being throughout my studies. My father deserves the highest praise in this acknowledgement as it has always been his wish to see me with the title of ‘Doctor’ added to my name. I am grateful for his guidance that gave me the confidence to keep pushing myself for my self-development. I am forever indebted to Mr. Javed Akhtar for his support and motivation to pursue my Ph.D. degree. Lastly, I would like to thank all my friends, who were there for me whenever I needed them during this journey. Special appreciation goes to Safiatou Kouma and Adam Pelka for their care, support, and well wishes during this time-period.

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ABSTRACT

This research aimed to analyse the applicability of Service Dominant Logic (SDL) in the healthcare sector of Pakistan. The author wished to make original contributions to SDL by providing empirical findings from the private healthcare clinics operating in Pakistan, with the aim to generalize the results with other developing countries having similar institutional/management settings. Doing so required the adaptation and modification of an SDL theoretical framework, that could justify the findings in context to the way healthcare businesses are conducted in Pakistan and similar developing countries.

The need for developing an 'SDL Presence Framework in Healthcare' originated from the different characteristics that the customers of healthcare (patients) exhibited in comparison to the conventional business consumers. Identification of a different market for patients (Business-to-Patients 'B2P') led to designing the SDL Presence Framework, that could facilitate contextual and empirical measurement of SDL. The fulfilment of the aims of this research required data from more than one source. Therefore, the author progressed with conducting two case studies that could justify the findings and warrant the validation of empirical evidence.

The author acquired permission to conduct research from the CEOs of two private healthcare clinics operating in Pakistan. Original identities of both organizations are changed due to the concerns of data confidentiality. The scope of this study was two private healthcare clinics (operating in Pakistan) that are present in different socio-economic settings and serve patients adhering to dissimilar social constructs/norms. The case study findings were useful in terms of identifying the differences in healthcare practice, which exist between developed and developing countries, and also within the scope of a developing country (heterogenous socio-economic societies).

Results from this research confirmed the need to segment customer market in the healthcare sector and warranted the contextualization of value, so that it may be better understood in dissimilar economic settings as well as in the institutional parameters of national culture. Moreover, this exploration has been able to challenge the core of Service Dominant Logic by demonstrating that the theory on institutional arrangements fails its application to all the exchanges, when examined in the context

of the developing world.

This research has generated valuable insights that contribute to the development of SDL theory and practice in the healthcare sector. A strong attempt is made by the researcher to discuss the findings on the micro (organizational), meso, and macro (societal) levels of the service ecosystem. Empirical outcomes from the case studies have implications for SDL theory, general practitioners, the Pakistani healthcare system, and the relevant committee of the World Health Organization (WHO).

CHAPTER 1 – INTRODUCTION

INTRODUCTION

This chapter explains the reason to carry out the research and summarizes what the upcoming chapters will follow. It also outlines why the research was undertaken, clarifies the focus of the study, and outlines the structure of the thesis.

1.1 BACKGROUND TO THE RESEARCH

Over the past few decades, service marketing and service operations took a big shift in terms of how organizations create value for their customers and manage their associations with service beneficiaries. This transition became more obvious in 2004 when the authors, Vargo and Lusch, published an article that advocated for a new dominant logic for marketing. This evolution was primarily focused on the change from a traditional view of service marketing, which saw service providers as the creators and deliverers of value, to value cocreation where the service providers and beneficiaries engaged in a set of activities that lead towards value creation for both. Terms like service-to-service exchange and value exchange started to be highlighted in the scholarly community more often, where the researchers began to see customers as an active part of a service ecosystem (Ballantyne and Varey, 2008; Akaka and Chandler, 2011; Anderson and Ostrom, 2015). Since then, a greater sense of service exchange responsibility is seen to lie towards customers, who previously were merely perceived as passive recipients of value, that was seen to be generated and delivered to them by the firms.

Amongst many other changes that started taking place in the service economies, the healthcare sector saw a transformation from providing 'social profit' to the community to evolving into a service business (Gandolf, 2020; Purcarea, 2019: 93). This shift brought healthcare business in the same scenario where firms started focusing on creating value together with the service beneficiaries i.e., patients (Purcarea, 2019:93; Krisjanous and Maude, 2014). Several studies have since been published in the last decade that focus on creating more value for the service beneficiaries in the healthcare sector (Mcoll-Kennedy et al., 2012; Ng and Vargo, 2018; Osei-Frimpong et al., 2018). Asmany service providers in the developed countries have moved their

focus towards the inclusion of service beneficiaries in their service design and value creation mechanism, developing countries are seen to lag far behind in providing basic healthcare services to the patients (Angeli and Jaiswal, 2016: 487). World Bank and WHO released figures in 2015 stating that an estimated 400 million people lack basic healthcare services globally, with a major chunk comprised in developing states. Residents of developing countries usually face worse conditions of life expectancy and health status as compared to the developed ones, low public health spending, in this case adds burden to people residing (especially) in the rural settings (Guo and Li, 2018: 176). When it comes to the quality of healthcare provided in those countries, it is observed that the appropriateness for resource-poor settings has received little attention, and improvement in quality healthcare remains sporadic in developing states (Leatherman et. al., 2018: 799). Many measures have been taken to overcome this issue including WHOs Framework for Action (2007), Millennium Development Goals (MDGs), and Alma Ata Declaration to help developing countries provide basic healthcare to individuals residing in the respective countries (Worldbank, 2017; Leatherman et. al., 2018; O'Donnel, 2007), but the progress recorded in the third world countries is still far from the desired goals (WHO, 2021). For this very purpose, World Health Organization came up with a strategy in the 1990s to improve planning, development, execution, and financing of health policy to help construct fair financing of a decentralized health system worldwide (UN-Pakistan, 2021).

Apart from many strategies, policies, and developments that are intended for the developing world, the service marketing theory brought by Vargo and Lusch (2004) seems to be a radical new approach that can contribute towards better healthcare provision in the majorly deprived areas. Service Dominant Logic (SDL) is introduced by Vargo and Lusch (2004) with its prime focus towards the understanding that service is the fundamental basis of all exchange. This theory asserts that all providers are *service* providers and value is co-created with customers and assessed on the basis of value-in-context (Vargo and Lusch, 2004). Since 2004, many researchers have taken interest in this new conceptual lens, which has led to the theory on SDL being refined multiple times by the authors (Vargo and Lusch, 2004). To this date, there have been eleven foundational premises (FPs) and five axioms of SDL that have been introduced by Vargo and Lusch (2015, 2004) and will be extensively discussed in the literature chapter.

SDL is of interest to this study based on the claim that value creation is always unique to its settings and actors, rendering it as a highly contextual outcome. The theory on SDL claims that the only way forward for service businesses is to engage with service beneficiaries and through their competencies cocreate value with one another. If that is found true in the empirical settings of the healthcare sector, SDL can prove to be a successful strategy in alleviating the challenges of the developing world. Although most of the work on SDL is in a theoretical context, the author has come across some studies where the researchers have applied the premise of SDL to certain empirical settings (Osei-Frimpong et al., 2018; Yan and Kung, 2018). The majority of the studies are confined to marketing and client relational contexts; however, some explorations tend to explore the impact of SDL on the healthcare sector. An example in this regard is the research by Osei-Frimpong et al (2018) where the researchers have tried to evaluate patient cocreation activities in healthcare delivery on a micro-level. Another example is the research by Yan and Kung (2018) which tends to provide theoretical support for SDL and cocreation of value provided by healthcare organizations. Researchers in this study examined relationships, competence, willingness, and value cocreation to improve the empirical grounding of SDL.

While such studies can be seen as a progression for SDL theory, the researcher has been able to identify certain key areas where the empirical expansion of this theory is highly warranted but has not yet been developed. Although it has been almost two decades since SDL became the center of attention for many academic scholars, there has not been enough empirical evidence that could authenticate its applicability in the healthcare sector of the developing world. Certain questions remain unanswered, for example, how and if value cocreation can vary between the developed or developing countries? And if the value is subjective to receiving audience based on social constructs? An answer to these questions is necessary to understand the functioning of SDL in diverse empirical settings. Developing countries are seen to demonstrate an environment where quality provision of healthcare services is seen to be lagging in both public and private sectors (WHO, 2021). The researcher intends to conduct this study to verify if SDL can work to be a solution for the deteriorating conditions of the healthcare sector in developing countries (Angeli and Jaiswal, 2016; Shaikh and Hatcher, 2017). To the best of the researcher's knowledge, there are not many studies that compare the findings of developed countries with the healthcare setups of

the developing ones. Differences occurring in the perceptions, socio- economic conditions, and culture of developing countries are some highly important factors that may result in different outcomes as to the ones yielded from developed states. Reasons for these 'gaps' can be understood to be arising as SDL is still deeplyrooted at the theoretical level. There is a strong need for empirical evidence and operable frameworks that could verify the promising theoretical basis of SDL in the real world.

Discussing healthcare service delivery problems in the developing countries, it is seen that a huge gap exists between the proposed and actual health spending (Public health sector) of many developing states. The required spending for critical health services proposes that the lack of availability is a root cause in the majority of occasions (Gordon et al., 2020: 2). Also, the under-utilization of health services in the public sector has been reported for being almost a universal phenomenon in developing countries (WHO, 2021). A general trend in developing states portrays a system where the public sector encompasses basic health units, dispensaries, hospitals, and rural health centers that are under the control of respective governments, while the private sector incorporates small hospitals, maternity care, dispensaries, and medical general practitioners treating patients in their private medical clinics (Anwar et al., 2012: 513). Generally, private medical clinics (service businesses) in developing countries operate in a form of small setup (or SMEs) comprising of 1 or more general practitioners running the entire medical clinic (Khursheed *et al*., 2015: 739). The rationale for operating in such capacity is interlinked to the overall economic situation of the country (in this case Pakistan) where these healthcare clinics garner to a stronger sense of community, serving to the needs of socio-economic societies they are established in (Anwar et al., 2012: 513). Therefore, the employees working in these clinics are kept below a certain threshold, that could ascertain economic affordability at one end, and operational viability on the other. For example, the staff present in these premises may include few male and female nurses, medicine compounders and/or pharmacists, front desk staff, and security personnel (EMRO, 2021). Also, the private practitioners set up their practices from their resources and provide services by charging fees (WHO, 2021). These clinics usually provide healthcare services to walk-in, pre-registered, or emergency patients (EMRO, 2021). There are generally four types of healthcare services that private healthcare clinics provide to the patients. They include primary

care, secondarycare, maternity care, and dispensaries (WHO, 2021).

As aforementioned, healthcare has evolved into a service business that works on the principles of a ‘for-profit’, rather than a 'social profit' phenomenon. To obtain research authenticity, it was necessary to study developing countries that exhibit the dominance of the business nature of healthcare. Pakistan fits well with the scope of this study as the country's private sector shows complete dominance over the entire healthcare service delivery. While the Private sector took care of 75% of the total curative services in Pakistan in 2020, with the majority of the population considering the public sector of low quality (WHO, 2020), the country saw a major shift of patients acquiring medical treatment from private institutions as compared to the public ones (Anwar et al., 2015). Overall Private healthcare clinics established a good record for saving many infants, maternal and young children’s lives in resource-constrained settings (Brugha & Aliassime, 2003). Moreover, the private sector addressed the fast-developing need for healthcare education in Pakistan to a great extent (Shaikh, 2015). According to a survey conducted in 2015, the private health sector was found to be providing 79% of medical treatment (4% increase from 2007) to the general population (Shaikh, 2015). Worsening of country’s economic conditions and democratic instability is considered to be the cause of the escalation to this percentage (Khursheed *et al*., 2015: 737) as more and more patients prefer private healthcare resulting in an increased workload on private practice (Aljunid, 1995; Malik & Syed, 2012). The decision to choose Pakistan for assessing the impact of SDL in developing countries is based on the fact that the country is the fifth most populated state in the world (worldometers, 2021), and falling into the category of a developing nation, yields a huge number of cases requiring proper medical attention daily (Anwar et al., 2015).

The problem, however, lies in the fact that private healthcare, although being better than the public sector and with all the above-mentioned contributions, has been lagging in providing satisfactory treatment and customer care to the patients (Malik & Syed, 2012). As the developed world is progressing towards mutually creating value with the service beneficiaries, the patients visiting private healthcare clinics in developing countries are mostly found to be dissatisfied with the service deliveries. From comparing multiple studies (Ahmed & Shaikh, 2008; Khowaja, 2009; Malik & Syed, 2012), it has come to surface that private medical clinics in Pakistan are also lagging especially in service delivery, leaving the patients displeased during or after

the completion of their treatment. Some examples of the reasons for dissatisfaction include the long waiting time of patients in clinics (Schectman *et al*., 2005: 715) and errorsin medicine prescription in the private practice (Jeetu & Girish, 2010: 60), etc. Healthcare in Pakistan appears to lack both a comprehensive and a competent service delivery structure (Khowaja, 2009: 264). Given the comparison between the two healthcare systems of Pakistan, the author of this study decided to focus on the private healthcare of Pakistan (rather than public) mainly due to the reason of access to the healthcare setups and to stay within the given timeframe of this research. As the public healthcare sector is driven mainly by the policies drafted on the government level (Lakshminarayanan, 2011: 26), it would be rather difficult for the author to get access to the policymakers of both developed and developing countries. Alternatively, considering private healthcare not only helped the author to avoid multiple layers of hierarchy for reaching the policymakers/government employees (in case of public healthcare), but also helped in availing easy access to the stakeholders i.e., CEOs, of private healthcare practices. Hence the viable option for completion of this research on time was to opt for private healthcare setups in Pakistan.

An underlying factor seems to be a lack of recognition across multiple disciplines that effective service delivery is critical for patient wellbeing and organizational and economic success. This perceived lack of recognition seems to be common in many service sectors of developing countries (Lewis, 2019).

Therefore, the chief agenda for this research is to evaluate the applicability of SDL in empirical settings from a developing country, in support of growing the development of SDL theory and to authenticate if the empirical findings can help to better the healthcare service delivery in the developing world.

1.2 RESEARCH FOCUS AND OBJECTIVES

The research aim is to understand how Service Dominant Logic might be applied in the private healthcare empirical context of a developing country i.e., Pakistan, and to capture any lessons that might be useful for theory development. Achieving the research aim will require the researcher to meet three research objectives:

1. To apply and adapt a framework based on the interpretations from the axioms and Fundamental Premises of SDL theory – which would facilitate the evaluation of SDL by determining its presence within the private healthcare organizations of Pakistan.
2. To evaluate mutual value creation in different socio-economic societies of Pakistan by assessing the presence of different service relations within a private healthcare setup.
3. To assess the application of SDL presence framework of healthcare in Pakistan, within the context of empirical evidence and SDL theory.

To achieve the aims and objectives of this research, the author decided to conduct two exploratory case studies in different socio-economic areas of a developing country. As private healthcare businesses in developing countries are majorly classed as small businesses (Khursheed et al., 2015: 737), it is found that conducting exploration of two setups will help in comparing and contrasting the results, for better authenticity. The richness of information needed will only be possible if SDL is tested in more than one empirical service context, that too being exploratory with in-depth details. Moreover, the author and his supervisory team agreed over exploring two private healthcare clinics so that the service business perspective realistically replicates a service exchange context inwhich both parties had a strategic incentive to engage in value co-creation. The author expressed interest in exploration with the CEOs of both healthcare clinics before the commencement of the research. The request to explore the clinics was accepted by both the CEOs of Clinic-A and Clinic-B, who demonstrated high interest in this opportunity to understand and improve their businesses respectively.

As the scarcity of literature on SDL in healthcare is mentioned earlier, the researcher used all available secondary data to create a framework specifically designed for healthcare setups. Henceforth, the author was able to apply and adapt a theoretical framework for assessing the presence of SDL in both healthcare clinics (Clinic-A and Clinic-B). The research strategy included collecting primary data from both healthcare clinics that would entail the monitoring of service exchange processes, patient satisfaction, self-observation, and analysis of documentation to understand service

exchange interactions. However, the main primary data collection tool for this research is focused on interviews from patients, GPs, and staff of the studied healthcare clinics. Further steps required the author to compare and analyze the findings with secondary data on SDL and healthcare information acquired from the studies focusing on developing countries.

As service is the basis of all exchange in SDL, the author needed to map the complete service design of both healthcare clinics. Also, the fact that both clinics were chosen in different socio-economic areas within a developing country, allowed the researcher to assess SDL and its applicability presence with different contextual settings. Taking advantage of conducting explorations in different socio-economic settings, the author ensured to evaluate value perceptions for the service actors in both clinics. This approach gave the author further in-depth data that could help build SDL theory based on real-world empirical grounding.

1.3 STRUCTURE OF THESIS

The thesis is divided into 7 chapters including the Introduction. The structure for the remaining 6 chapters is as followed:

Chapter 2: Literature Review

This chapter discusses the changes that marketing and economics had gone through since the 19th century. The narrative is built in a form of a timeline where the presence of goods dominant logic (GDL) is discussed followed by the development of SDL theory, its fundamental premises, and the final modification to SDL Axioms. The author has tried to demonstrate how the understanding of ‘value’ has changed over time through numerous academic inputs. The chapter progresses towards a discussion of an SDL conceptual framework followed by identifying the knowledge gap that is focused on the healthcare sector. The end fragment of this chapter is based on the critical analysis of healthcare and discusses the role and applicability of SDL in this specific area of interest. This chapter also introduces a model that captures the need for a new market for healthcare (B2P) after assessing multiple pieces of literature

relative to the study. Lastly, this chapter sheds light on the different practices of healthcare between developed and developing countries and also, goes into further depth where the differences in practice within the developing countries are observed.

Chapter 3: Methodology

This chapter focuses on research methodology, the philosophical assumption, and details the data collection and analysis process.

Chapter 4: Findings – Clinic-A

This chapter details the findings acquired from Clinic-A based on evaluating SDL presence and mutual value creation. Findings of Clinic-A are organized in a manner that allows discussion of all the elements of the SDL presence framework in healthcare respectively. A background of Clinic-A, its operations, and service design is provided followed by identifying the contextual and value creation dynamics. Photographic evidence is also compiled in this chapter that demonstrates a true picture of services that are provided to the patients. The researcher has included a pie chart that is based on certain elements that determine the perceptional value of patients in Clinic-A. Finally, the overall satisfaction of service beneficiaries is evaluated based on the different components of value, as discussed earlier in the literature review chapter. The findings reveal variations between the segments in both transactional dynamics and mutual value creation.

Chapter 5: Findings – Clinic-B

This chapter is organized in a similar way as to the findings of Clinic-A. All the elements discussed are sequential which includes, describing the results of a customer satisfaction survey, analyses the causes of dissatisfaction, and discusses the implications for customer perceptions of value creation. Overall satisfaction for the service beneficiaries of Clinic-B is also assessed using the same components of value as previously done for Clinic-A.

Chapter 6: Discussion

A very detailed discussion chapter is presented in this thesis that validates the need for a separate market for healthcare consumers. The scope of discussion around the findings highlights the significance of determining value (empirical) in both case studies and thus tries to specify the true nature of 'value' in developing countries. This chapter leads on to examining the impact of institutional arrangements in the micro and macro settings. Moreover, the determination of SDL in Clinic-A and Clinic-B is followed, based on the SDL comparison framework in healthcare. Implications for SDL theory are presented towards the end of the chapter which entails each of the five axioms of SDL theory.

Chapter 7: Conclusion

The final chapter of this thesis presents an overview of the case studies and summarizes how the aims and objectives of this research were fulfilled. This is followed by the future implications and contributions to theory and practice.

CHAPTER 2 - LITERATURE REVIEW

INTRODUCTION

This chapter delivers an in-depth review of existing literature around numerous concepts considered vital to this study. It presents an overview of development through which the modifications and adaptations in the marketing theory took place, justifying the need for a new paradigm through which marketing could be seen. The significance of Service Dominant Logic (SDL) and its theoretical foundations are deliberated, followed by a critical review of its foundational premises and discussion around aspects related to service-providing organizations. The knowledge gap found among the reviewed literature is then highlighted and finally, the constructs that contributed towards the development of the theoretical framework are presented. The literature also presents a comparison between developed and developing countries when examined under the horizon of SDL in healthcare settings.

2.1 GOODS DOMINANT LOGIC (GDL)

The understanding of marketing and economics was mostly developed in the nineteenth century (Vargo and Lusch, 2004: 14; Fullerton, 1988: 108; Petty, 2019), and during this era of the industrial revolution, the utmost focus was seen towards the efficiencies in the production of tangible output. The emphasis of firms/industries started steering towards the achievement of ‘economies of scale’, and through the mass production of goods, organizations started competing against one another to capitalize their shares in the market (Vargo and Lusch, 2004: 5). This gave birth to the traditional notion of marketing management (Webster, 1992), where the acceptance and practice of ‘Product, Place, Price, Promotion, (4 Ps) strategy were believed to be the only way forward for successful firms. Organizations viewed ‘value’ to be embedded into a good (during the production process) and thus, made strategies focusing on the 4Ps to achieve their economic and financial goals. This concept has been highlighted by Vargo and Lusch (2004) as ‘Goods Dominant Logic’ (GDL) in their pioneering article, where the key purpose of firms is seen as; ‘production’ and ‘distribution’ of goods in the form of tangibles. The two authors

elaborated GDL as a process in which the economic exchange (on a basic level) is conducted by dealing with tangible units of output (goods), which are installed with value amid the assembling procedure (Vargo and Lusch, 2004). Although, Vargo and Lusch (2004) particularized the concept of GDL to lay foundations for their newly introduced conceptual model i.e., 'Service Dominant Logic' (SDL), many scholars (Harrington et al., 2019; James Anderson et al., 2006; Skålén et al., 2014) have since been noted to take interest in GDL to explore its significance and practicality in the modern world. From the mentioned information it can be deduced that GDL is defined as a process that uses a 'coproduction' approach, in which customer value is primarily transactional and could be regarded as value-in-exchange (Harrington et al., 2019: 253). Co-production here is defined as an exchange of products and services between the customer and the service providers which is established on a platform of simultaneous production and consumption (Chathoth et al., 2013: 11). However, it must be noted that GDL emphasizes a production- oriented philosophy in which service plays a secondary role (Prahald and Ramaswamy, 2000: 83). There are certain characteristics of the coproduction approach that have been outlined by the research community, they include; firm being the center of value creation, ignoring the significance of reciprocity between organizations and customers, and ignoring the potential for the mutual dependence of organizations and customers in service production (Chathoth et al., 2013; Lusch et al., 2007; Kristensson et al., 2008; Harrington et al., 2019).

An important factor describing GDL is the fact that this concept is based on 'superior offerings' (Lanning and Micheals, 1988: 3). According to Anderson et al. (2006), superior offerings are defined as goods that resonate with customer needs, providing all the benefits that the customer would achieve from the market offering. The superiority of these offerings also means that the offered goods must demonstrate the favorable points of difference to the next best alternative (competitors) and should resonate with the key focus of goods that would deliver the greatest value to the consumer (Anderson et al., 2006: 3). As the factor of superior offerings is inter-connected with value propositions, in simple terms, this means that the value is proposed by the companies/organizations through 3 steps which include choosing, providing, and communicating the 'better proposed' value that is embedded in the product (offering), as identified by Lanning and Micheals (1988). Ballantyne et al. (2011) further elaborated on this concept by stressing that 'superior offerings' are

the value propositions by companies through which these firms deliver their value to the customers. An important factor that is highlighted in Ballantyne's research is the distinct classification that value propositions are constructed without any customer involvement (Ballantyne et al., 2011: 203s). As this statement completely ignores the role of customers in the value proposition, authors like Bititci et al. (2004) have been reported to propose that value propositions (in GDL) may sometimes be cocreated within a network of providers that may involve market research. Here it can be seen that the role of customers, though indirectly, is touched upon by the authors when explaining the GDL approach of marketing (Bititci et al., 2004). To further understand this difference of opinion within academic researchers, the study of Anderson et al. (2006)is seen to be central as it argues that value propositions should resonate with the customer needs, recommending market research to accomplish this criterion.

Contrastingly, the majority of the authors argue that value propositions are fundamentally supplier-led initiates to external and internal stakeholders, who are involved in communicating the superiority of their market offerings by showcasing their unique, valuable differences as compared to their competitors (Anderson et al., 2006, Ballantyne et al., 2011; Araujo and Pels, 2015). A study by Skalen et al (2014: 33) regards the concept of value proposition in GDL as 'heavily supplier centric' and views supplying company as; *the entity solely responsible for the production, identification, and delivery of consumer value*. Furthermore, GDL has been explained in the recent publications by authors such as Terho et al. (2012: 13), as a phenomenon in which firms are engaged to display their superior offerings in the market by their value propositions treated as 'quantifiable evidence' of value. These examples can be seen as arguing towards the understanding that customers have no power to create or shape value propositions. In-depth understanding of this concept also suggests that the customers, under this logic, are targeted with a generic, pre-packed offering, which outlines the benefits and expected costs that the offering entails and that the value provided by the companies is subsequently used or destroyed by the customers (Vargo and Lusch, 2004). An important factor of this logic stresses the fact that the value of goods is signified by market price or what the customer is willing to pay. It is, therefore, through economies of scale and standardization, that maximum profit and efficiency are achieved (Vargo and Lusch, 2008).

Vargo and Lusch (2004) argued in their article that there is a distinction between the manufacturer and client in GDL and that the value is seen to be created in a linear and step by step fashion. The fact that customers have no power to shape or create value proposition is stressed by many authors exploring this dominant logic (Ballantyne et al., 2011; Araujo and Pels, 2015; Skålén et al., 2014; S. Vargo and Lusch, 2015). Due to such a scenario, the communication is observed to be 'unidirectional' and flows from the producer towards the end consumer. It is therefore important to understand the difference of opinion of various academic researchers in this particular concept and to understand the true essence of GDL, which will be discussed in the upcoming sections.

2.2 GDL AND THE ROLE OF OPERAND RESOURCES

'Goods Dominant Logic' is a terminology adopted by Vargo and Lusch after the amalgamation of what previous scholars described as; 'neo-classical economy' (Hunt, 1983), 'product marketing' (Shostack, 1977), 'marketing management' (Webster, 1992) and 'manufacturing logic' (Normann, 2001). The common denominator amongst all the explorations led Vargo and Lusch to understand, emphasize and elaborate on the significance and nature of *operand resources* in GDL (Vargo and Lusch, 2004).

It is to be noted that Lusch and Constantin (1994) were the first researchers who came up with the terminologies i.e., operand and operant resources in their book; 'Understanding Resource Management'. They defined operand resources as the resources that require action taken upon them to be valuable (Lusch and Constantin, 1994). Vargo and Lusch (2004) further clarified the definition and stated them as the resources on which an operation or act is performed to produce an effect. Moreover, an understanding amongst scholars was developed with time that these resources are tangible assets that are factors of production, such as raw materials or machinery (Araujo and Pels, 2015). In this regard, the researchers quoting the research by Lush and Constantin (1994) stated that: "*Operand resources are essentially tangible, including natural resources, raw material and entity commodity, etc., generally located at a passive position in production activity*" (Li et al., 2018: 648). The exploration of the concept of GDL has revealed that operand resources are the main component of this

logic and hence, the table below has been adapted from Vargo and Lusch (2004) to demonstrate their importance:

	GOODS DOMINANT LOGIC (GDL)
Primary unit of exchange	People exchange for goods. These goods serve primarily as *operand resources.*
Role of Goods	Goods are *operand resources* and end products. Marketers take matter and change its form, place, time and possession
Role of customer	The customer is the recipient of goods. Marketers do things to customers; they segment them, penetrate them, distribute to them, and promote to them. The customer is an *operand resource.*
Determination and meaning of value	Value is determined by the producer. It is embedded in the *operand resource* (goods) and is defined in terms of 'exchange-value
Firm-customer interaction	The customer is an *operand resource*. Customers are acted on to create transactions with resources.
Source of economic growth	Wealth is obtained from surplus tangible resources and goods. Wealth consists of owning, controlling, and producing *operand resources.*

Table 2.1: GDL & Operand Resources - Adapted from Vargo and Lusch (2004)

In GDL, operand resources are considered a primary source of a firm's competitive advantage. From these assertions, an understanding develops that the object of economic exchange is to create and deliver objects to be sold. Relating this concept with value and how it is seen under this logic, GDL is seen to stress the fact that value is created *internally*.

To fully understand how the 'value' (in GDL) is created 'internally', it is crucial to address the important concepts of *competencies* or *capabilities.* A related article in this regard, is found to describe organizational capability as "*a high-level routine (or collection of routines) that, together with its implementing input flows, confers upon an organization's management a set of decision option for producing*

significant outputs of a particular type" (Winter, 2003: 991). Alternatively, another article is observed to define competence as an aptitude to withstand the harmonized deployment of assets (which can be tangible or intangible and could be used by the firm for the processes of producing, crafting and/or offering the products to the market) in a manner that aids the firm to achieve its goals (Sanchez and Heene, 1997). Because of the similar conceptualizations of competencies and capabilities, they can thus be equated and defined as 'a combination of tangible and intangible resources, being socially complex and fitting together coherently to allow organizations to produce valued market offerings efficiently and effectively' (Madhavaram and Hunt, 2008: 69). From the stated literature an understanding is seen to develop at this stage i.e., capabilities of organizations can be looked upon as the abilities either demonstrating an 'internal' nature or 'external' (Madhavaram and Hunt, 2008; Vargo and Lusch, 2015). The firms concentrating more on tangible assets, with a focus on production and crafting could be seen as the ones demonstrating 'internal capabilities' as opposed to the organizations who are focused on intangible assets and consider the value to be created externally (with the customers). This concept of internal and external capabilities is also stressed upon by the researcher, David Teece (1997), who argued that it is the 'dynamic capabilities' of firms that shows their ability to build, integrate and reconfigure external and internal competencies to address rapidly changing environments. The concept of dynamic capabilities is further deliberated upon in the upcoming section of critical analysis on GDL.

Linking the literature back to the concept and understanding of GDL, it is understood that firms (under this logic are believed to) emphasize on developing 'internal capabilities' as opposed to focusing on cocreating value with the consumers and stakeholders (Vargo and Lusch, 2004: 5). In other words, the customer value proposition in GDL can be seen in a company's context as anticipation to discover consumer needs only through direct interaction and subsequently offering a solution to that need(Ballantyne et al., 2008). Following this thought, a conceptual gap can be observed in GDL, where the need for and importance of relation-building between firms and customers is seen to be missing. Following the study of Ballantyne et al (2008), it isobserved that all focus is stressed on operand resources, and customer relationships are seen to be based on product-centric assertions, which in turn,

diminishes the role of services and relationship quality. Furthermore, it is seen that the companies view consumers as 'passive' and the flow of communication is unidirectional. This statement again goes against the notion of a customer-centric approach which has been highlighted by the authors such as Bower and Garda (1985) and Lanning (1998),who assert that consumers cannot be seen as passive under the principles of a customer-centric approach. Recent studies on customer dominant logic (CDL) have also been observed to discredit the efficacy of GDL by arguing that value is not limited to the resource frame of the service which is controlled by the organizations, instead, it is created as a part of customer's dynamic and multi-faced reality (Heinonen et al., 2013; Voima, 2010; Tynan et al., 2014). These uncertainties and gaps in GDL raise further questions as to how the firms can identify the needs of consumers and effectively address those needs without the use of relationship building, sharing knowledge, and having a two-way flow of information? (Bower and Garda, 1985; Ballantyne and Varey, 2008; Vargo and Lusch, 2004; Lanning, 1998).

If the research of Bower and Garda (1985) is considered, an assertion of GDL can be observed that suppliers can recognize and predict customer value as a result of traditional marketing efforts such as consumer research. According to this statement, a generic value proposition is seen to be designed to fulfill those needs. This notion of GDL is also seen to be questioned by the scholarly community (Vargo and Lusch, 2004; Prahald and Ramaswamy, 2000) as it lacks the detail on how firms target individual or specialized needs of customers without the use of knowledge and dual-way interaction. Hence this logic is seen by Vargo and Lusch to completely ignore customer participation or involvement in service designing or value creation (Vargo and Lusch, 2008).

2.3 CRITICAL ANALYSIS OF GDL

As aforementioned, the term 'Goods-Dominant Logic' was introduced by Vargo and Lusch in 2004. Based on their reflection of GDL and the need for a new paradigm, Vargo and Lusch (2004) came up with a new dominant logic i.e., Service-Dominant Logic (SDL), which is going to be the focus of attention in the upcoming sections of this research. However, studying the concept of GDL in-depth reveals some important points that contradict the 'generalizations' made in the article by the two authors. Starting from the research of Tadajewski and Jones (2020), it appears that both of

these authors oversimplified the transition of 'GDL' to 'SDL' to a factually inaccurate narrative. In their exact wording, the authors are reported to have said that, "*We believe that alleged transition from GDL to SDL is a myth*…" (Tadajewski and Jones, 2020: 114). Furthermore, the authors raised speculations regarding the timeframe of 1900-1950, which has been typically associated with the GDL thinking era by Vargo and Lusch in 2004. Looking at the article by Vargo and Lusch (2004) it is seen that the trend shown by the authors depicts a transition from a production focus to a relationship focus. In other words, it can be deduced from this statement that the focus on relationships had not been given due importance in the past (early 20th century). Tadajewski and Jones (2020) reject this statement by stating the concepts of service capitalism and service socialism, which were not only driven in this time period but also focused on the importance of an ethical relationship with the consumers. They used these examples in their article to justify why from the late 19th century, service was postulated as axiology for describing and explaining the success of capitalism in contradiction to socialist thinkers (Tadajewski and Jones, 2020: 118). Multiple pieces of research back the findings of these authors such as; Sheldon (1913), Baker (1957), Miller et al (1975), and Filene (1929). One example in this regard is taken from the research of Sheldon who is reported to have said: "*To secure long-term profit, one had to be fair, sincere and appreciate the need for mutually satisfying exchanges*" (Sheldon, 1913; Tadajewski and Jones, 2020: 118). All the above-mentioned studies point that the term GDL, constructed by Vargo and Lusch (2004), is a result of historical limitations and lack factual grounding (Baker, 1957; Miller et al., 1957; Filene, 1929).

Moving forward, Vargo and Lusch have portrayed GDL in their articles in a manner that represents it as a 'primitive' and non-viable logic in the modern times. Their articles advocating for a change in marketing theory stress readers to accept the notion of SDL, which is the only way forward according to both authors (Vargo and Lusch, 2004). However, research conducted by Teece (2018), reveals that focus on production is equally important to the emphasis being laid on relation-building and service centricity. Teece (2018) is also observed to stress the understanding and adaptation of a good business model, which is specific to every company in the present day and age. The researcher, in this regard, is reported to have said: "*The business model provides a pathway by which technological innovation and know-how combined with the utilization of tangible and intangible assets are*

converted into a stream of profits" (Teece, 2018: 40). From this statement, it is observed that the focus on both tangible and intangible assets leads towards profitability (Ritter,2014).

From the comparison of above-mentioned studies, it becomes necessary to pinpoint the lack of depth in Vargo and Lusch's (2004) article to understand the foundation of the capability view of the firms. A limitation is seen in their research that reflects a scenario where the focus on production is seen to overshadow the relationship focus that has been a part of firms' capabilities in the era of mid and early twentieth century. As the authors stress that generic pre-packed value (in the production phase) is provided to the customer (Vargo and Lusch, 2004: 7), still does not explain the significance of relationship focus through which the needs of customers are communicated, understood, and warranted by the companies to deliver production excellence (or advantage). Taking Barney's (1991: 101) research into consideration, a firm's capabilities are defined to be both tangible and intangible in nature. Similarly, another study in the 1980's is reported to incorporate intangible skills as an element of a firm's capability i.e., technological skills, to look at economic units in terms of their resource endowments (Wernerfelt, 1984: 171). Whereas Vargo and Lusch (2004) have been seen to associate GDL merely with the production focus in terms of validating the philosophical lens introduced as service dominant logic.

All of these studies suggest that the research by Vargo and Lusch (2004, 2008, 2016) is full of limitations and several factors have not been incorporated that could prove their terminology of GDL and its concept to be ineffective as opposed to their introduced dominant logic. More empirical research is needed to establish if the claims by authors are accurate.

2.4 STAGNANCY IN MARKETING THEORY AND NEED FOR A NEW PARADIGM

Bringing forward the viewpoint of Vargo and Lusch (2004), the history of 'call for a new paradigm' can be seen stretching back to over 150 years when Fredrick Bastiat argued that, 's*ervices are exchanged for services',* advocating his criticism towards the 'then prevailing' and widely accepted Goods-Dominant view (Bastiat, 1995; Vargo and Lusch, 2004). As it was an era of the industrial revolution, the concept provided by the author was mainly ignored and disregarded in the research community. It was after

150 years that the authors; Vargo and Lusch (2004) came up with an article that stressed upon a new dominant logic and advocated for an innovative paradigm, that became a center of attention for the research community (Vargo and Lusch, 2004).

Before discussing the new paradigm and its implications, it is pertinent to mention the role of researchers who criticized the effectiveness of GDL, regarded its existence and limitations, and pointed towards the stagnancy in the marketing theory. The contribution of researchers like; Prahald and Ramaswamy (2000) needs special mentioning as they raised their concerns regarding the acceptance of the 'passive' role of customers when it came to value creation. The two authors rejected the idea that value is merely created by the manufacturer and laid the groundwork for the term 'value cocreation', implying that customers and manufacturers create value collectively in the real understanding of marketing theory (Prahald and Ramaswamy, 2000). Also, the crux of the views represented by authors such as; Gronroos, 1994; (Kotler, 1997); (Schlesinger and Heskett, 1991), helped in the understanding that the goods-dominant view of marketing not only fails to interpret the full role of services but it also hinders a complete understanding of marketing in general. Furthermore, researchers such as Gummesson (1994), was seen to challenge the notions of GDL related to buying a good with pre-packed value. Through the efforts of the scholarly community, an idea was seen to be emerging that, "*Customers do not buy goods or services: They buy offerings which render services which create value*…" (Gummesson, 1994: 12).

All inputs from the above-mentioned researchers led to an understanding by the scholarly community that marketing theory had reached a state of stagnancy and the need for new paradigms was becoming necessary. The new paradigms would have to be divergent from the traditional notions of marketing theory (Vargo and Lusch, 2004) and based on services for the future of marketing. Vargo and Lusch (2004), while stressing the future of marketing, emphasized the shift of marketing from a tangible (goods-based dominant logic) towards an intangible (service-based dominant logic).

2.5 INTRODUCTION TO SERVICE DOMINANT LOGIC AND OPERANT RESOURCES

Service Dominant Logic (SDL) is a service-centered substitute to the traditional goods-centered paradigm for understanding economic exchange and value creation that has been acknowledged as an appropriate philosophical foundation for the development of service science (Vargo and Akaka, 2009; Vargo and Lusch, 2004). SDL is grounded on the idea that service is the fundamental basis of value creation through an exchange. Vargo and Lusch (2004) have defined the role of service as 'the application of competences for the benefit of another' and imply that *service is exchanged for service,* and the involvement of goods is to be seen as service-provision vehicles only (Vargo and Akaka, 2009: 32). In other words, the fundamental concept of Service Dominant Logic (SDL) stresses that humans apply their *competencies* to benefit others and reciprocally benefit from others' applied competencies through a service-for-service *exchange*. This overall process results in the *cocreation of value* between all the actors involved (Vargo and Lusch, 2004).

To fully understand the concept of SDL, it is necessary to comprehend the keywords that are used to construct this definition. Vargo and Lusch (2004: 7) defined *specialized competencies* as; skills, knowledge, and expertise that an individual, organization, or market possesses for the benefit of a party. The core idea presented by the two authors stresses the unified understanding that 'services are *exchanged* for services' and all social and economic actors (e.g., customers, firms) are service providing, value-creating enterprises' (Vargo and Lusch, 2004). Furthermore, *Value cocreation* is seen as an intrinsic concept of SDL (Vargo and Lusch, 2008) and is described as the 'benefit achieved from the integration of resources' through activities and interactions with collaborators in the customer network (McColl-Kennedy et al., 2012).

Linking the concept of SDL with the literature of Lusch and Micheals (1994), it is observed that the first definition of *operant resources* or 'specialized competencies' was provided by the two authors who stated that: "*Operant resources are essentially intangible, continuous, and dynamic, mainly including knowledge and skill. These resources can be evolved, transferred or redoubled, generally located at an active position in production activity*" (Li et al., 2018: 648; Lusch and Constantin, 1994). SDL asserts that marketing is moving away from the Goods-Dominant view (based

on the transaction of tangible goods) to a service dominant view, which focuses on intangible resources and relationships as the fundamental source of value. This understanding brings another significant aspect to light that, *service exchange occurs between actors through intangible resources,* and thus, it is argued that *no* physical goods are exchanged under this conceptual lens. Chandler and Vargo (2011: 41) described it as the active participation by all the social and economic actors (who are regarded as resource integrators) and connected in embedded systems of service exchange. Through the pioneering article by Vargo and Lusch in 2004, the two authors re- introduced the concept and significance of *operand* and *operant* resources, which is vital to the understanding and application of SDL. It was asserted that service-centered dominant logic perceives operant resources to be *primary* because they are the producers of effects (Vargo and Lusch, 2004). Hence, this shift is in the prevalence of resources and has insinuations for how markets, customers, and exchange processes are approached. Table 2.2 demonstrates how operant resources are viewed in SDL with comparison to the operand resources as discussed earlier in this section:

	SERVICE DOMINANT LOGIC (SDL)
Primary unit of exchange	People exchange to acquire the benefits of specialized competences (knowledge and skills), or services. Knowledge and skills are operant resources.
Role of Goods	Goods are transmitters of operant resources (embedded knowledge); they are intermediate 'products' that are used by other operant resources (customers) as appliances in value creation processes.
Role of customer	The customer is a co-producer of service. Marketing is a process of doing things in interaction with the customer. The customer is primarily an operant resource, only functioning occasionally as an operand resource.
Determination and meaning of value	Value is perceived and determined by the consumer on the basis of 'value in use'. Value results from the beneficial application of operant resources sometimes transmitted through operand resources. Firms can only make value propositions.
Firm-customer interaction	The customer is primarily an operant resource. Customers are active participants in relational exchanges and co-production.
Source of economic growth	Wealth is obtained through the application and exchange of specialized knowledge and skills. It represents the right to the future use of operant resources.

Table 2.2: SDL & OPERANT RESOURCES - ADAPTED FROM VARGO ANDLUSCH, 2004

Moving forward, actor collaboration is seen as a critical factor in SDL, as they are observed to interact in order to enhance resource density, expand the set of resources available to them and lead towards increasing value creation (McColl-Kennedy et al., 2012). In simple words, individual actors pursue value through service-for-service exchanges that are the basis of dyads, triads, complex networks, and service ecosystems (Chandler and Vargo, 2011: 41). It can be deduced from the information present on SDL that the recognition of beneficiaries as cocreators of value is based

on the objective to derive maximum value out of a service relationship and to satisfy customers at the uppermost levels, leading towards the formation of long-term and successful business relations. Vargo and Lusch (2016) demonstrated the process of SDL comprising of 5 factors which include actors, resource integration, service exchange, institutional arrangements, and service ecosystems. The diagram is as followed:

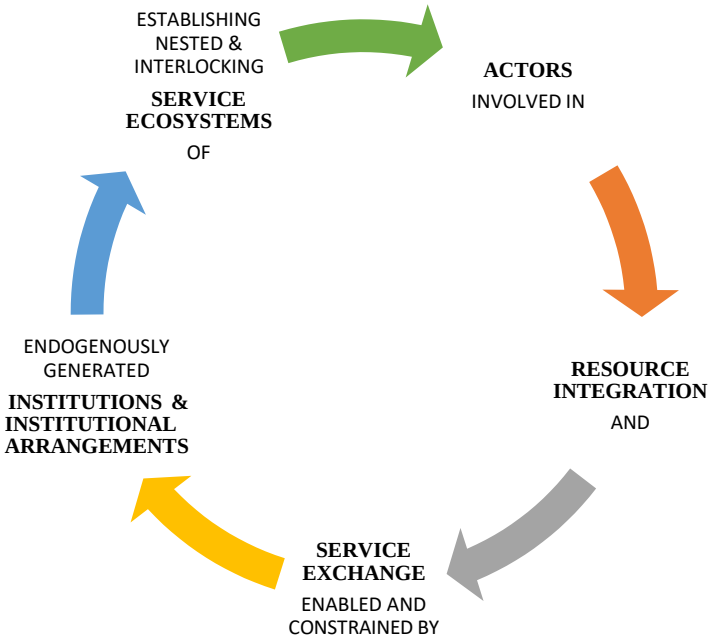


Figure 2.1: Narrative and process of SDL (Vargo and Lusch, 2015)

2.6 FURTHER DEVELOPMENT OF SDL THEORY

Moving on to the theoretical development of SDL, it is noticed that researchers like; Alderson (1957) and Kohli and Jaworski (1990), who are believed to be influential

marketing thinkers, served in laying the foundations of SDL. Similarly, research on collaborative value creation by Norman and Ramirez (1993) and Prahalad and Ramaswamy (2000) provided the groundwork for developing the concept of value cocreation. The input from these researchers proved vital to the construction of SDL and led to the point where this logic is gaining increased scholarly attention worldwide. Undoubtedly the work by Vargo and Lusch (2004, 2008) has been central to the development of SDL, it is crucial to realize that many other studies provided a foundation for the development of this topic as well (Alderson, 1957; Kohli and Jaworski, 1990). An example in this regard can be taken from the study of 'consumer culture theory' (CCT), which is central to the core of SDL research during the early development years i.e. 2004-2008 (Arnould and Thompson, 2005).

Researchers like Gronroos (2011) not only influenced SDL research in the formative years but also in recent times by bringing in concepts through his proposed service logic, along with an alternative customer dominant view on value creation (Heinonen et al., 2013; Grönroos, 2011). All these developments suggest that the respective studies have been closely related and have contributed considerably to the development of this conceptual lens.

Vargo and Lusch claim that, since 2004, countless researches have been conducted, through which the concept of SDL is being extended and further consolidated (Vargo and Lusch, 2015). It is therefore important to understand that the pioneering article written by the 2 authors (Vargo and Lusch, 2004) can only be seen as an integrative literature review in which certain ideas were presented, which described the trends in marketing thought and gained a lot of attention in the scholarly community. These ideas were then integrated into a coherent framework and summarized into a set of Foundational Premises (FPs). The realization that some of the premises are not hypothesis or propositions (in the sense of being empirical), reveals that the FPs are 'concisely expressed statements of a coherent philosophical lens' (Williams, 2012) and produced to examine the markets and marketing in general. The original FPs provide a framework for analyzing marketing phenomenon and are the constructs that challenge the orthodox marketing assumptions. The original 8 FPs are mentioned in the table below:

FOUNDATIONAL PREMISES (FPs)	
FP1: Application of specialized skill and knowledge is the fundamental unit of exchange	FP2: Indirect exchange masks the fundamental unit of exchange
FP3: Goods are distribution mechanisms for service provision	FP4: Knowledge is the fundamental source of competitive advantage
FP5: All economies are service economies	FP6: The customer is always a co-producer
FP7: The enterprise can only make value propositions	FP8: A service-centered view is customer oriented and relational

Table 2.3: Foundational Premises of SDL (Vargo and Lusch, 2004)

Taking a deeper look into the development of SDL, it is observed that this concept did gain a lot of attention from the scholar community and numerous studies have since been published that discuss its intricacies (Lusch and Vargo, 2006). Like any other pioneering study, Vargo and Lusch faced a lot of criticism with regards to this newly introduced dominant logic and through their articles (2006, 2008, 2011, 2016, 2019), confronted various critiques by clarifications and/or modifications in the original 8 FPs, that underpin the logic. The responses received towards the formation of SDL can be categorized into two groups: The first group focused on the development of this logic by critically discussing the sensitive text and context issues (Ballantyne and Varey, 2008; Vargo and Lusch, 2008; Lusch and Vargo, 2006). An example in this regard can be taken from the article by Ballantyne and Varey (2008: 5) where it was argued that *'dynamic co-creational activity can take place within 'integrated' networks of suppliers, competitors and customers working together and yet competing',* as a suggestion to the views presented in the article by Vargo and Lusch in 2004. Another example can be taken from researchers, who identified the introduction of SDL as a significant turning point in service marketing research and a shift from a focus on services (plural) to a service (singular), the application of knowledge, and skills for the benefit of others (Baron et al., 2014: 158).

The second group, however, can be categorized as ‘cautious’ and skeptical towards one or more aspects of the dominant logic. Gronroos (2006: 319) for example, observed that ‘consumption of goods is a closed system for the firm and the process of consuming the goods is treated as a black box’. This led him to question whether SDLalways ends in more effective marketing (Grönroos, 2006: 329). The response to such critiques has been noticed in the publications by Vargo and Lusch, and in this specificcase, the extension of the original 8 FPs (Vargo and Lusch, 2004) was seen to be composed of 2 additional FPs in 2008 (Vargo and Lusch, 2008).

The 8 FPs published in the article by Vargo and Lusch (2004) were updated by Vargo and Lusch in 2008 with an addition of two more FPs, followed by the 11th premise in 2016. Due to these modifications, SDL has redefined the nature of service exchange by neglecting the previously accepted ‘goods dominant logic’ and considering all parties in a service relationship as ‘actors’ in a broad service ecosystem. The table below demonstrates SDL and its status in the currently modified and accepted state:

Axioms	Foundational Premises	Description
1. Service is the fundamental basis of exchange	FP 1	Service is the fundamental basis of exchange
	FP2	Indirect exchange masks the fundamental unit of exchange
	FP3	Goods are distribution mechanisms for service provision
	FP4	Operant resources are the fundamental source of strategic benefit
	FP5	All economies are service based economies
	FP6	Value is co-created by multiple actors, always including the beneficiary

2. Value is cocreated by multiple actors, always including the beneficiary	FP7	Actors cannot deliver value but can participate in the creation and offering of value propositions
	FP8	A service-centred view is inherently beneficiary oriented and relational.
3. All social and economic actors are resource integrators	FP9	All social and economic actors are resource integrators
4. Value is uniquely determined by the beneficiary	FP10	Value is always uniquely & phenomenologically determined by the beneficiary
5. Value cocreation is coordinated through institutions and institutional arrangements	FP 11	Value co-creation is coordinated through actor-generated institutions and institutional arrangements

Table 2.4: Foundational Premises Development (Axiom Status) (Vargo andLusch, 2015)

DEVELOPMENT OF AXIOMS

To understand the crux of the 5 axioms of SDL, it is necessary to explain how certain FPs are merged and the significance of each component.

AXIOM 1

The 1st axiom of SDL, *service is the fundamental basis of exchange*, is shaped by the combination of the first 5 FPs of SDL (Vargo and Lusch, 2016). This axiom signifies the meaning of service (singular) and services (plural) under the conceptual lens of

SDL. In-depth research of this axiom signifies the imbalance of skills present amongst various people in a society and stresses the engagement of the exchange process of skills to produce a beneficial output. The first 2 FPs stress on the application of operant resources (skill, knowledge, expertise, etc.) where 'services' are seen to be exchanged for services according to the definition of SDL published in the article (Vargo and Lusch, 2004). Focus is deliberated on the understanding that because service is being provided through a complex combination of institutions, capital, and goods, the service basis of exchange is not always apparent. In other words, it is reflected that service may or may not involve physical objects, in a case where it does, the physical objects are just a means to provide a service (transmission mechanism). The 3rd FP holds high significance as it challenges the previously followed notion of Goods Dominant logic. It states that both durable and non-durable goods derive their value through use i.e., the service they provide. According to the 4th FP of SDL, operant resources are the fundamental source of strategic benefit. This means that the comparative ability to cause desired change drives strategic benefit. The 5th FP of SDL considers all economies as service-based economies and denotes that service itself has become more apparent with increased specialization and outsourcing.

It is to be noted that the original first FP introduced by Vargo and Lusch in 2004 stressed the relationship between a company and consumer. After scrutiny by scholars like Ballantyne and Varey (2008), a revised update by Vargo and Lusch (2008) clarified that the definitions of customers and companies constrict scholars to perceive the exchange process in a broader social and economic context. The word 'unit' was also replaced with 'bases' of exchange to bring clarity to the conceptual lens introduced by the 2 authors. However, some issues of understanding like; the actual ability of actor/s to implement the skills and the concrete process for the 'application of skills and knowledge' were deliberated by the scholars while exploring the topic of SDL. A number of authors reflected on the relationships between employer-employee and supplier-buyer and questioned how this lens could be seen to include these relationships while viewing marketing from this dominant logic? Another research questioned the practicality of this axiom by questioning the intra-company relationships i.e. employee-employee relationship and regarded this collaboration as a complex phenomenon (Vespestad and Clancy, 2019: 5). Factors like interpersonal skills and administrative support were deliberated in this research to question the

authenticity and practicality of the 1st FP of SDL. Lastly the question as to if and how the sequences and activities can influence outputs of the exchange process were highlighted and was argued along with the absence of contextual variation in the premise. Hence, empirical evidence must be provided from the operational businesses. Another article in this regard is observed to question the same concept that, even though SDL signifies that customers cocreate value, there are limited studies that demonstrate how customers engage in value cocreation (Zhang et al., 2015: 201).

AXIOM 2

The second axiom, *Value is cocreated by multiple actors, always including the beneficiary*, and the 6th FP of SDL asserts that value is not embedded in goods. These statements emphasize the fact that value occurs when the good is utilized, rather than when it is being exchanged (in contrast to GDL). With the assertion that customers are cocreators of value, Vargo and Lusch tried to resolve the discrepancy surrounding the postulation that companies produce value, and the customers consume them (Vargo and Lusch, 2016). Lusch and Vargo (2014) clarified this point in their article that value derives from the use and integration of resources. This statement reveals that customers have to understand how they can adapt to the product according to their specific/unique needs, which in turn signifies that they (beneficiaries) are the co-creators of value (Vargo and Lusch, 2008). Furthermore, the 7th FP of SDL argues that firms only offer value propositions and therefore, cannot deliver value. This has been further explained in the article (Vargo and Lusch, 2014) where 'value propositions' are elaborated as an appeal to collaborate with a company for the benefit of both parties. To understand the context of 'multiple actors' in the 2nd axiom, it is important to shed light on the 8th FP of SDL which deals with the marketing concepts of customer orientation and relationship marketing. As SDL distinguishes the nature of value creation, value is seen to be created over time through the relational intertwining of competencies and resources (Rittmeyer, 2016). It is thus understood that through continuous communication, actors realize what the other party values, and therefore, relationships amongst actors are inherently beneficiary-oriented.

AXIOM 3

The 3rd axiom of SDL, *All economic and social actors are resource integrators*, and FP 9 states that the actors cocreate value through the exchange of service rights. It is important to understand that, before the construction of Axiom 3, Vargo and Lusch were criticized by the scholarly community for portraying the interaction taking place (FP 9) on a micro-level. However, in 2014, both the authors stressed the fact that actors are not separated entities from the environment, as depicted in the structuration theory, and are both at the effect as well as the creator of their environment (Rittmeyer, 2016; Lusch and Vargo, 2014). Taking on a macro-level approach, the authors argued that service-to-service provision exchange is only a fraction of the conditions needed to cocreate value. To understand this point, an example from the article by Lusch and Vargo (2014: 245) is taken where the authors are reported to have said that "*It is not simply acquiring services (resources) from suppliers but rather integrating these services (resources) with internal resources and public resources to create a market offering that reflects a compelling value proposition*." By this statement, it is understood that resource integration can also be seen as an innovative process (Skålén et al., 2014). As all social and economic actors are resource integrators, the integration of resourcesresults in new resource creation, which subsequently is used by different actors to repeat the cycle.

AXIOM 4

Axiom 4 and FP 10 states that *Value is always uniquely and phenomenologically determined by the beneficiary.* This has been explained by Vargo and Lusch (2014) on the basis that every service-for-service exchange takes place in a unique context. It is important to realize that the term 'beneficiary' depicts the generic nature of the actors involved. Axiom 4 reinforces the concept that value is experimental, and the main focus is towards 'value propositions', that are perceived and integrated differently by each actor. Hence, it can be understood that value is uniquely experienced and determined (Vargo and Lusch, 2008). Another way of explaining this axiom requires the understanding that value must be understood in terms of the holistic combination of resources that lead to it, in the context of other (potential) resources (Chandler and Vargo, 2011). The overall understanding asserts that Value is always unique to a

single actor, can only be determined by the actor, or by keeping the actor as the central referent.

AXIOM 5

The 5th axiom and 11th FP of SDL focus on the role of institutions and institutional arrangements that play an important role in the value cocreation process. It is, however, crucial to understand that the term institutions do not refer to organizations, as misunderstood by various scholars after the publication of the pioneering article on SDL by Vargo and Lusch (Vargo and Lusch, 2016). The two authors clarified this concept in their updated article that institutions are referred to as; norms, rules, and beliefs that enable and constrict action and resultingly, make the social life predictable and meaningful (Vargo and Lusch, 2016; Scott, 2001; North, 1990). Institutions and institutional arrangements explained as an upper tier set of interrelated institutions, enable the actors to accomplish an increasing level of service exchange and value cocreation under cognitive and time constraints in a service ecosystem (Vargo and Lusch, 2016). A point of understanding arises from this concept that the benefit of this 'perpetually beneficial service exchange' is gained at a cost, which means that the influence of institutionalization can trigger unavoidable conditions, such as service relations that are mutually requisite. Vargo and Lusch (2016) stressed that the existence of rules and norms can diminish flexibility and social freedom for the actions with service relations. This implies that value cocreation is a cycle, a closed loop that binds together the actors of service exchange (Vargo and Lusch, 2016).

Before going into the assertions of Vargo and Lusch regarding ecosystems and service exchange, it is important to realize that these concepts have been discussed by early scholars in a similar context, if not the same. The example in this regard can be taken from the research of Alderson (1965), who presented institutions as endogenous to marketing systems and stressed that the interaction amongst various systems leads towards the rules of institutions and conducts. In another example, Layton (2011) touched upon the concept of service ecosystems with the association to marketing systems. This research perceived knowledge and institutions as being exogenous to marketing systems, in a manner of being influenced and influencing, at the same time (Layton, 2011).

However, Lusch and Vargo (2014: 240) defined service systems as, "*a relatively self-contained, self-adjusting system of resource integrating actors that are connected by shared institutional logics and mutual value creation through service exchange*." In other words, service ecosystems are described to be formed when actors excel in providing progressive amalgamations of resource application, which results in the development of complex exchange systems. Within these ecosystems, all actors are constantly engaged in many *processes* (Vargo and Lusch, 2008). An important point discussed in the research by Vargo and Lusch emphasizes the fact that the 'processes' mostly do not initiate or end with a single actor's action, rather they are set into continuous configuration motion and integration of resources that eventually empower the value cocreation process (Lusch and Vargo, 2014). As per the understanding of SDL, these ecosystems can be seen as a combination of people, technology, and resources that engage amongst one another to generate mutual value. However, Vargo and Lusch in 2016 clarified that the focus of service ecosystems moves from technology to institutions and the knowledge exchange is considered to be endogenous to such systems.

Vargo and Lusch have used the term service ecosystems to clarify the extended systems of service exchange, this is noted to be the reason for the nature of interactions, which is based on an environment in which different actors engage for the flow of intangible resources (Vargo and Lusch, 2016). Some authors have since raised concerns over the definition of service ecosystems (Ballantyne and Varey, 2008; McColl-Kennedy et al., 2012) as to indicating and limiting to the role of technology. Vargo and Lusch (2015) cleared this misconception by stressing that the service ecosystems do resemble service systems that are embedded within the SDL, however, there is a key difference that service ecosystems focus on the role of institutions rather than the role of technology. Contrastingly, and on another account, the two authors have been reported to have said that, "*technology and institutions may manifest direct linkages in such that technology in itself is a transfer of knowledge that in turn is a part of an institution*" (Vargo and Lusch, 2015: 17).

An important outcome of the article by Vargo and Lusch (2015) revolves around the fact that earlier notion of value cocreation in SDL gave the impression that focus exists within a dyadic relationship between the actors, however, the clarity that value is anticipated for multiple actors (not only involved in dyadic exchange) and involve

others, clarified the concept of service ecosystems and role of actors involved in the service exchange. Nevertheless, there is no empirical evidence to the clarification brought in about by the two scholars (Vargo and Lusch, 2016) and a real-life case study can prove to be a considerably good option for the justification of these propositions.

From the information presented above, an understanding develops that SDL views service systems as a configuration of people connected by institutions and institutional arrangements, which are described as beliefs, norms, and rules that facilitate or constrict the service exchange (Vargo and Lusch, 2016). Nevertheless, the distinction between institutions and technology is deemed contextual and on multiple occasions, technology is referred to as an institution itself (Vargo and Lusch, 2016). Other contextual factors associated with the institutional arrangements like norms, beliefs, and rules, as defined by Vargo and Lusch, also lead to opening up new horizons to study the role of institutions and institutional arrangements in an empirical setting. Healthcare setups in this regard can prove to be an ideal context for studying the empirical application and existence of service dominant logic. It is observed that healthcare setups can act as the perfect organizations for empirical evidence as 'technology-enabled services' are justified as a *need* for 'care'. An example in this regard can be taken from the NHS 2030 report by Nesta, which states that:

"*Digital technology should be assessed in the context of healthcare to create technology- enabled services, redefining new services and changed new institutes of care"* (Nesta, 2015: 09).

As healthcare in itself is an institution based on rules, norms, and beliefs, the arrangements can provide empirical evidence to the propositions laid by Vargo and Lusch for the value creation and significance of SDL. Moreover, many researchers have already stressed (Elg et al., 2013; McColl-Kennedy et al., 2012; Mankiw, 2017) the need for empirical evidence when it comes to healthcare and the factors influencing institutional assurance of service quality to the patients. Researchers such as Akaka and Chandler (2011) have also been reported to study the role of SDL when it comes to the institutional arrangements of the healthcare industry. Empirical evidence has since been stressed over the factors such as; service engagements, where the social roles might project some behaviors which would influence the actor's expectations (Akaka and Chandler, 2011).

2.7 FOUNDATIONS OF AN SDL CONCEPTUAL FRAMEWORK

After synthesizing the information acquired from studied pieces of literature, the author of this research has attempted to formulate a framework that captures the core dynamics of value cocreation based on the FPs of SDL and the core dynamics of service exchange that outline the overall outcomes of mutual value between the actors involved. The framework is intended to be used as a tool for the determination of 'the presence of SDL' in the healthcare system of Pakistan, within explicit contextual service exchange scenarios.

The constructed 'SDL Presence Framework' adapts its roots from the various studies (Elg et al., 2013; Mcoll-Kennedy et al., 2012; Lubeck et al., 2000b; Friere and Sangiorgy, 2010; Vargo and Lusch, 2015) that the author believes have an apparent influence in shaping the nature of service relation, mutual value creation, and subsequently the overall presence of SDL. The author has categorized those elements to form the key constructs of the SDL Presence Framework and has mentioned them below for a deeper understanding of this concept. As the focus of this research is deliberated towards the understanding of SDL in healthcare environments, the author intends to use this framework to determine the presence of SDL in healthcare organizations which are based on the synthesis of 2 core aspects.

Before discussing the core aspects, it is necessary to map what studies have contributed to categorize the elements for the determination of SDL Presence Framework. Table 2.5 is therefore presented below that provides a clear mapping:

	ELEMENTS OF SDL	STUDIES
VALUE COCREATION DYNAMICS	SERVICE DELIVERY PROCESS DESIGN AND BENEFICIARY'S INVOLVEMENT	Shostack (1982), Anderson and Ostrom (2015), Vargo and Lusch (2015), Stickdorn and Schneider (2010), Patricio et al (2018)
	INTENSITY OF KNOWLEDGE TRANSFER	Vargo and Lusch (2004), Vargo and Lusch (2008), Druscat (2005), Spohrer et al (2008), Randall et al (2015), Brodie et al (2011), Capon and Glazer (1987)
	RELATIONSHIP MANAGEMENT BETWEEN SERVICE PROVIDER AND BENEFICIARY	Schneider and Bowen (1985), Hochschild (1983), Leidner (1991), Rafeli (1989), Gutek (1995), Gittell (2002), Light (2001), Payne et al (2008), Wolter et al (2017), Ryals and Davies (2013), Ming-Huei and Wen-Chiung (2011), Salojarvi et al (2010)
CONTEXTUAL DYNAMICS	TOP MANAGEMENT COMMITMENT	Weiner (2007), Anderson et al (2007), Blumenthal et (1995), Natti and Palo (2012), Jones et al (2009), Mankiw (2017), Ojasalo (2001), Vespestad and Clancy (2019), Asree et al (2010), Valmohammadi (2017), Flynn et al (1995)
	RESOURCE ORIENTATION	Vargo and Lusch (2004), Zeelenberg and Pieters (2004), Ojasalo (2001), Yan and Kung (2018), Ballantyne et al (2008), Pels (2012), Frei (2006)
	SERVICE ORIENTATION	Lytle and Schiling (1994), Lytle et al (1998), Lee et al (2006), Lynn et al (2000), Yoon et al (2007), Kandampully et al (2011), Frei (2006), Vargo and Lusch (2004), Vargo and Lusch (2008), Kimbell (2011)

Table 2.5: Studies contributing to the identification of SDL elements

A. **Value Cocreation Dynamics** are the elements that the author believes to carry high significance when determining the cocreation of value in healthcare settings. These dynamics can be understood as the transactional intricacies through which services are exchanged between the two actors (Healthcare organizations and the Patients). The arrangement of said dynamics in a way that portrays; designing of service delivery process and the beneficiary's involvement, the interflow of operant resources by the intensity of knowledge transfer, and the nature of relationships between the actors involved, can be seen to portray the real essence of Value Cocreation-Dynamics.

B. **Contextual Dynamics** on the other hand, can be understood as the behavioral/cultural intricacies that develop from the perceptions of actors towards service delivery and service relations. Consequently, this sets the context of service exchange and influences the outcomes derived from the Value Cocreation Dynamics. The collection of the elements such as; top management commitment towards service relations, resource orientation (perception towards resources to be exchanged amongst actors), and service orientation (significance of delivering services to beneficiaries) can be referred to as Contextual Dynamics.

2.7.1 VALUE COCREATION DYNAMICS

2.7.1.1 SERVICE DELIVERY PROCESS DESIGN AND BENEFICIARY'S INVOLVEMENT

The idea of designing services was first introduced by Shostack (1982) and following his research, various explorations started focusing on innovation and service solutions (Anderson and Ostrom, 2015; Vargo and Lusch, 2015; Shostack, 1982). Service design plays an important role in service innovation due to the innovative ideas that it brings to existence through a design thinking process (Anderson and Ostrom, 2015: 248) by realizing consumers and their context, predicting future service solutions, and prototyping them (Stickdorn and Schneider, 2010). Moreover, the way the

process of delivering a service is designed, presented, and executed greatly influences the outcome of service and how value is created from it (Vargo and Lusch 2016). This understanding of service design signifies that the value of a service can be modified, improved, and increased, thus making it crucial to explore how the mechanism of designing works in principle. However, it is critical to realize that the concepts of service design and innovation are poorly understood (Patrício et al., 2018: 5) and are constructed on multiple approaches, with different epistemological origins that are yetto be integrated.

Moving forward, the aspect of involving service beneficiaries in service designing has gained a lot of attention by researchers (Yu and Sangiorgi, 2017; Patrício et al., 2018; Steen et al., 2011) and is acknowledged that the process of delivering services is highly customer-centric (Steen et al., 2011: 6). An important study, highlighting the role of service design in SDL, is conducted by Yu and Sangiorgi (2018: 41) who argued that service design can orient new service development towards a service/customer- centric logic. The research presented various case studies to demonstrate how service design influences service innovation. It was found that service design reframes new service development processes for value cocreation through an all-inclusive understanding of user experience, codesigning practices, prototyping, and constructing long-term capabilities for supportive value creation (Yu and Sangiorgi, 2018: 41). The study by two authors contributed in the understanding to transform new service development process to better implement the value cocreation perspective by using the service design approach (Patrício et al., 2018: 5).

Following the last example, the researcher has considered the findings of Storey and Larbig (2017), who studied customer involvement in service design through the lenses of dynamic capabilities. Their article argued that consumers are a source of knowledge (outside of an organization), which can prove beneficial for the service design process (Storey and Larbig, 2017: 107). Although this article demonstrated limited involvement by the consumers, it showed that firms exploit customer knowledge in the form of a successful new service by the means of consumer involvement, knowledge assimilation, and concept transformation.

From the studied pieces of literature, the aspect of involving customers and other actors in the service design process can be seen as following a more participatory or

expert mindset (Sanders and Stappers, 2008: 49). This means, when the organizations tend to design and innovate for customers themselves, they are adopting an expert mindset approach. This phenomenon can be understood by the research of Patrício et al (2018: 6), who claims that firms asking customers for the solutions automatically leads towards incremental improvements to the existing services (Ulwick, 2002), but this is only limited to improving the service design that has already been created by the organizations. Under this scenario, the firms tend to learn from the experience of 'expert users of service' (consumers) and re-design/improve services from the received knowledge (Patrício et al., 2018). On the other hand, a participatory mindset of service designing signifies that the organizations can adopt *codesign* processes with the customers, where the firm and other actors mutually engage in service designing and innovation (Sanders and Stappers, 2008). Such firms tend to see the consumers as true experts in areas of experience such as, working, living, or learning and bring themto actively participate in the design decisions.

From the SDL perspective, the work of Kimbell (2011) is seen to be relevant as it provides valuable insight on the designing of services process from a marketing and operations perspective. The author argues that service designers consider services as both material and social entities, and thus services are progressively considered as relational (Kimbell, 2011). This relates to the study of Cipolla and Manzini (2009), who regard services as relational and view service design as a constructive phenomenon. As service designers are seeking to understand customer experiences as crucial determinants of value (Patrício et al., 2018; Krisjanous and Maude, 2014; Hardyman et al., 2015; Cipolla and Manzini, 2009) and involving them in service designing activities, the notion of SDL, detailing actors' co-involvement and cocreation of value can be seen to emerge. An understanding emerges at this point that the service providers and service beneficiaries can increase the value they create by collaborating in a service relation (Vargo and Lusch, 2004). This concept reflects a strong desire of the service provider to mutually create value with the beneficiary and a stronger aptitude towards SDL.

Concludingly, it can be said that the deeper the beneficiary is involved in the service design process, the stronger the presence of SDL would be. This understanding will help the author of this study to determine/measure the presence of SDL in healthcare

institutions.

2.7.1.2 INTENSITY OF KNOWLEDGE TRANSFER

SDL views knowledge, skills, and abilities as operant resources (Vargo and Lusch, 2004) with the purpose to create service-based value. In the original article, Vargo and Lusch (2004) regarded knowledge as a fundamental source of competitive advantage. Though the terms ‘knowledge’ and ‘competitive advantage’ were substituted in 2008 by ‘operant resources’ and ‘strategic benefit’ respectively (Vargo and Lusch, 2008), the authors emphasized that value creation involves direct application of skill and knowledge to create service. Transfer of knowledge between various actors of the service ecosystem is deemed necessary (Vargo and Lusch, 2004) to distinguish between the term ‘knowledge’ and ‘knowledge in use’. This concept has been touched upon by Druskat (2005), who termed *knowledge in use* as ‘applied knowledge’ and a crucial factor for value creation. The core idea of this concept is to convert knowledge, which is dynamic and evolutionary, into compelling value propositions. These value propositions in turn help organizations to mutually cocreate value with the actors and further research of this concept reveals the bottlenecks that organizations may incur to use this operant resource for achieving benefit ‘in application’ (Druskat, 2005). Research by Spohrer et al (2008) argues that the knowledge embedded in people is the most fundamental type of operant resource but difficult to transfer, copy or combine. This could be the reason for, for example, failed expected synergy value or failed mergers, etc. Contrastingly, knowledge encoded as information or technology is easily copied or transferred (Spohrer et al., 2008). Nevertheless, the significance of knowledge transfer in both scenarios is critical for the firms to mutually cocreate value with the service beneficiary (Spohrer et al., 2008; Vargo and Lusch, 2008).

Moving towards the arguments of Vargo and Lusch (2008), it is established that operant resources are the key to gaining strategic benefits and the centrality of knowledge is a core determinant of this benefit and value. The researchers such as Capon and Glazer (1987) have been reported to stress the importance of the centrality of knowledge and have provided findings that favor the concept of knowledge in use in their research (Capon and Glazer, 1987). Moreover, studies have been conducted that provide a robust framework on SDL’s focus on knowledge and how its integration

helps firms to leverage supply chain competencies to improve value (Randall et al., 2015; Brodie et al, 2011; Vargo and Lusch, 2004).

From the discussed pieces of literature, the understanding that comes forward is that the intensity of knowledge transfer reflects the intensity of operant resources, hence, the higher the intensity of knowledge transfer is, the higher the presence of SDL would be noted in an organization (Vargo and Lusch, 2008). In terms of healthcare, the case studies portraying more knowledge transfer between the service beneficiary and service providers would indicate a strong presence of SDL, and vice versa.

2.7.1.3 RELATIONSHIP MANAGEMENT BETWEEN SERVICE PROVIDER AND BENEFICIARY

An increasing focus of scholars towards the relationship management between the service provider and beneficiary can be noticed in the late 20th century, where several articles were published, stressing the need for good relationships in the service industry (Schneider and Bowen, 1985; Hochschild, 1983; Leidner, 1991; Rafaeli, 1989; Gutek, 1995). These studies range from air travel, fast-food restaurants, retail stores, nursing homes, and hospitals (Wrzesniewski and Dutton, 2001), with the findings stressing the importance of relationship management between the service provider and beneficiary (Gittell, 2002). The concept of 'customer relationship management' (CRM) is also believed to surface due to the input from the researches conducted in the 20th century and is explained as; *CRM evolved from business processes such as relationship marketing and the increased emphasis on improved customer retention through the effective management of customer relationships* (Light, 2001; Valmohammadi, 2017: 374). Relationship marketing here denotes the concept where customer retention affects the firm's profitability in a way where maintaining an existing relationship with a consumer is more profitable than building a new one (Payne et al., 2008). Other researchers like; Wolter et al (2017), discussed the role of relationship management by stressing that the adoption of such practice results in best business practice, knowledge management, and consequently, securing consumer's loyalty (Wolter et al., 2017).

Further development of relationship management leads to the development of models

through which important characteristics of a company's relations with beneficiaries could be realized (Ryals and Davies, 2013). An example in this regard is taken from the research of Ming-Huei and Wen-Chiung (2011), who created a model that portrayed 4 different types of alignments between a firm and its relations. The alignments stated by the two authors include opportunistic alignment, compensatory alignment, passive alignment, and mutualistic alignment. The researchers brought forward the findings which indicated concepts of behavioral norms and commitment to be crucial across different types of alignments between service providers and their relationship with service beneficiaries (Ming-Huei and Wen-Chiung, 2011).

Important research for the in-depth understanding of relationship management is conducted by Salojärvi et al (2010), who discussed the extent to which the relationship has to be strengthened between the service providers and beneficiaries. Their study discusses the scenarios where organizations need to be responsive towards 'better relationship' requirements put forward by the consumers. In doing so, the organizations have to adapt to an organizational structure that would improve their (firms') agility and readiness to respond to the needs and requirements of customers (Salojärvi et al., 2010). As responsiveness from the firm is not an easy task due to factors like 'formalization' and 'centralization', sometimes it becomes difficult for the companies to surpass the codes of conduct and existing business models to meet the unique requirements of strategically important customers (Gounaris and Tzempelikos, 2014). For such circumstances, customers typically expect to become more involved and to have a strong say in the development of the solution the firm offers, which in turn also points towards agile and customizable organizational structure (Vargo and Lusch, 2008). This means that managing the relations with beneficiaries may lead to structural reformation or change in the service delivery process/es to meet the needs of the consumers (Salojärvi et al., 2010).

As the term 'relationship management' suggests an association of more than one actor, it is necessary to understand that expectations can also arise from service providers towards the service beneficiaries. Vargo and Lusch (2008) have stressed the notion that service providers need to educate the beneficiaries as to what is expected from them. This concept has been derived from the research of Hunter (1987), who argued that many a time service beneficiaries do not realize what is expected from them by the service providers. In such scenarios, educating the

consumers can be seen as an efficient approach for transferring knowledge to match this gap (Spohrer et al., 2008). At this point, a relational approach can be seen as formulating from the above-mentioned pieces of literature where service providers can be seen as strengthening the relation into a mutual long-term agreement by educating the beneficiary (Spohrer et al., 2008; Vargo and Lusch, 2008).

Some scholars have been noted to point out the potential increase in firm's costs and lower profitability by adjusting to the requirements of service beneficiaries, specifically due to the aim to improve relations (Ryals and Davies, 2013; Homburg et al., 2002). These researchers have pointed out the financial benefits (rewards) that the customers might expect to build a long-term relationship with the service provider (Ryals and Davies, 2013). However, this notion has been challenged by the authors on grounds of the very basic definition of SDL, which stresses on the mutual value cocreation, stressing on benefiting all the actors in a service ecosystem (Zhang et al., 2015; Payne et al., 2008). To achieve the mutual benefit, a strong relationship between the actors along with adequate transfer of knowledge is deemed necessary. It is therefore understood that measuring the extent of the relationship between the service provider and beneficiary will depict a strong or weak presence of SDL, based on the grounds of the relationship maintained.

2.7.2 CONTEXTUAL DYNAMICS

2.7.2.1 TOP MANAGEMENT COMMITMENT

The impact of top management commitment (TMC) on the overall success of businesses has been described as *critical* in literature. The most important responsibilities of TMC, discussed in the studies, range from managing customer relations, quality, cost, and outcomes (Weiner, 2009; John Anderson et al., 2007; Blumenthal et al., 1995). Furthermore, the author of this research has come across various studies that stress the significance of TMC and its involvement in other important factors such as; service provision, allocation of resources, and overall service orientation (Nätti and Palo, 2012; Ryals and Davies, 2013; Jones et al., 2009).

A study by Weiner et al (1997) has been found to strengthen the findings of studied literature in the context of healthcare settings. The article stresses that low

involvement by top management in clinical settings is found to be highly unfortunate as the management is majorly responsible for controlling the clinical processes that impact costs, quality, and outcomes. Furthermore, it is argued that 'hospital-leaders' must devise strategies to increase clinical involvement in factors such as, quality assurance, if they wish to realize the benefits the firm expects to achieve (Weiner et al., 1997; Blumenthal et al., 1995). The article also argues on the principles of effective leadership by the top management, as it is a critical determinant to establish quality as a top priority, create a corporate culture, and mobilize the human and financial resources critical to support organizational learning (Weiner et al., 1997). Bluementhal and Edwards (1995), in a separate study on the healthcare sector, are reported to have stressed the fact that, lack of top management's involvement is a leading factor towards affecting the physician's behavior negatively. It is therefore pertinent to mention that the top management is believed to provide an atmosphere in which the employees (practitioners) confer a certain measure of autonomy in positive clinical decision making (Mankiw, 2017).

Moving forward, it is found that the scenario where TMC has a strong awareness about the significance of services while considering them important for the development of a long-term relationship with customers, leads towards intensified service improvement and resultingly, branches out to the other aspects of the business. Contrary to this scenario, having lesser commitment towards making service the crucial aspect of all operations, shifts the focus in a different place (Ojasalo, 2001). Under these circumstances, the firms are observed to concentrate on the involvement of operand resources rather than operant ones (Vargo and Lusch, 2004). This indicates giving more significance to automation and asset consolidation, for example, installation of machinery or equipment that reduces the requirement of human input (Vespestad and Clancy, 2019).

The recently published literature on TMC has been noticed to question the extent to which the 'commitment' is necessary for the lower hierarchy of organizations and the solution to homogenize this mentality in the overall organizational structure (Ryals and Davies, 2013; Asree et al., 2010; Valmohammadi, 2017). Therefore, it needs to be understood that having an intensified TMC with a strong focus on service excellence does not guarantee a similar mindset of the entire organization (Asree et al., 2010). Instead, it requires the use of effective leadership skills (Weiner et al., 1997) and efforts to safeguard that the SDL mindset is embedded across different levels of an

organization. In other words, top management's understanding of services, innovation, and value creation at top levels cannot be seen as a guarantee that the whole organization follows the same mindset. In other words, SDL implementation might become a challenge due to the lack of understanding by the lower-level organization staff. This in turn can be seen as weakening the outcomes of value (Vargo and Lusch, 2016). Asree et al (2010) have been seen reported to argue on the concept of 'service culture' in order to remove the obstacle of lower outcomes prevailing from the said conditions. The article by these authors states that*, In order to drive value co-creation that can create a more mutual outcome of value, top management should implement the right leadership and resource dissemination to develop a "service culture" among the employees* (Asree et al., 2010: 505).

It is observed through the studied literature that increasing the focus on mounting operational scale through tangible assets (operand resources) can take the attention away from the human factor of service delivery, which is an important constituent building relationship between intra-organizational personnel and service beneficiary's exchange process (Davies and Ryals, 2014). It is, however, crucial to mention the findings of two exploratory papers at this point for critical analysis of the understanding of TMC. Anderson et al (1995) and Flynn et al (1995) have argued in their studies that although TMC is pivotal to enhance the success rate of the firms, lack of serious evaluation regarding the efforts and resource requirements for value creation can push a company towards failure (Flynn et al., 1995). Therefore, top management must become involved in quality efforts at numerous planning and implementation phases to effectively lead the organization (Valmohammadi, 2017). If customer focus, benchmarking and employee empowerment have been effectively planned and tested, only than TMC has a high chance of creating mutual value creation with all the actors in a service ecosystem (Vargo and Lusch, 2008). It can be concluded from the presented literature that the presence of SDL in an organization can be measured by the nature of TMCs, in either being focused on service excellence or focused on tangible operational excellence.

2.7.2.2 RESOURCE ORIENTATION

The concept of operant and operand resources has been extensively discussed in this literature section along with the significance it holds for value creation (Vargo and Lusch, 2004). Past pieces of literature reveal that companies usually either focus on tangible or intangible assets when it comes to resource orientation (Zeelenberg and Pieters, 2004; Ojasalo, 2001). Generally, seeking either one of attributes depicts the preference of companies i.e., if the firm prefers employee's intangible skills over tangible assets (customization and machinery, etc.) or vice versa when it comes to building relations with the customers. Ojasalo (2001) stressed the attributes of the employees with intangible skills as the personnel having deep knowledge of service delivery along with shifting trends, flexibility, and willingness to learn new things, positive attitude towards customers, and proficiency in latest servicing techniques. This definition by the author can be seen as depicting the use of operant resources by an organization. Alternatively, tangible assets (operand resources) can be understood from an example of a firm using machinery for standardization and consequently having less ability to customize services (Vargo and Lusch, 2008).

Yan and Kung (2018) stressed the use of operant resources as a key driver in shifting a firm's attention towards SDL. This change is explained as the willingness and motivation of the company's management to focus on employing skilled staff who demonstrates the attributes of intangible assets, as explained in the article by Ojasalo (2001). Vargo and Lusch (2004) have termed this focus as a path towards achieving service excellence and creating mutual value creation with the service beneficiaries. It is pertinent to understand that this sort of thinking by the company's top management exhibits both contextual and value cocreation dynamics under which the goals are based on creating long-term service relations with the consumers, applying the right set of knowledge and skills, and using the resources that fit best for relation-building and creating value cocreation.

The alternative approach of companies anticipating and discovering consumer needs without the use of operant resources has been termed by Vargo and Lusch (2004) as operand-centric firms or simply, the firms following GDL. Ballantyne et al (2008) have been reported to present this culture as the one following 'systems' and offering standardized solutions (Pels, 2012) to the needs of the consumers by the methods of

mass production, etc. Critical analysis of both SDL and GDL has already been discussed earlier in this section, demonstrating the positives and negatives of both scenarios. As far as the focus on SDL is concerned, the emphasis on automation and standardization has been stressed to undermine the employees' abilities to cater to unconventional service beneficiary demands, which in turn impacts the relation-building and individualized relation management between the service provider and the beneficiary (Frei, 2006). Vargo and Lusch (2008) are of the view that operand-centric organizations distance the actors from mutually cocreating value by heavily relying on systems rather than people to provide service.

Through the understanding of both types of orientations i.e., operand-centric and operant-centric, a criterion is developed where empirical measurement of SDL can be achieved through realizing the firm's choice of operand or operant resources. If the organization portrays its orientation towards operant centricity via its TMC on service provision and mutual value creation, a strong focus on SDL can be concluded to be present. Alternatively, if the organization demonstrates strong reliance on operand resources via its TMC, a weaker presence of SDL is seen to be reflected.

2.7.2.3 SERVICE ORIENTATION

Service orientation is defined as "*a collection of organizational activities undertaken by service firms designed to secure the creation and delivery of excellent services in strategic response to market information*" (Lytle and Schilling, 1994). It is pertinent to mention here that the concept of service orientation stresses the creation of 'superior-services' and delivery of 'customer satisfaction' from the service providers. From the organizational context, service orientation is seen as the extent to which a firm adopts policies, customs, and procedures that are targeted towards rewarding and supporting service activities to create and deliver value (Lytle et al., 1998). Lastly, through a marketing lens, service orientation can be seen as a strategic response to market information that is designed to implement marketing concepts within the inclusive framework of customer-oriented services (Lee et al., 2006). Studies by numerous authors have been observed to claim that, the organizations that put strategic emphasis on providing superior services are better able to create value, as perceived by beneficiaries and employees, along with securing customer satisfaction that

ultimately results in higher profitability (Lee et al., 2006; Lytle et al., 1998; Lytle and Schilling, 1994).

Moving forward, Lynn et al (2000) were the first of the few researchers to pinpoint the relationship of service orientation with the intangible aspects of an organization (Yoon et al., 2007). They stressed that the organizations must accommodate customer needs by their 'organizational climate' which should demonstrate the culture of crafting, nurturing, and rewarding service practices and behaviors (Lynn et al., 2000). As service orientation is based on the attitudes and actions of its members (staff, stakeholders, etc.), the firms which can demonstrate accommodative service orientation do so by building strong relationships with the customers through the help of intangible aspects through its members (Yoon et al., 2007). Research by Kandampully et al (2011) gave further depth into this concept by finding that service orientation shapes employees' behavior and attitude by affecting the quality of interactions between organization and customer and consequently affecting the quality of service delivery process in a service organization (Kandampully et al., 2011). A study by Yoon et al (2007), conducted in the healthcare settings, also found that satisfied and trained hospital employees contributed more towards value creation with the patients as opposed to unsatisfied and untrained ones. Their finding suggested that top management's role is very important for service orientation to positively impact business performance and hospitals should continuously improve the service value received by patients.

Another important study by Frei (2006) concluded that the companies which focus on service excellence are naturally inclined towards service accommodation, while the companies focusing on operational excellence or cost optimization are more inclined towards service reduction. This study encompasses the concepts of TMC and choice of 'resource orientation' and shows a direct relationship with the service orientation being offered to customers by the organizations. Therefore, using Frei's framework, the author of this research will evaluate the presence of SDL in an organization, particularly determining the extent of SDL by evaluating the type of service orientation, the explored firms exhibit. For a clear understanding of both types of orientations, they must be defined according to the literature explored.

According to Frei (2006), service providers are more likely to adapt to a mindset of fulfilling individualized demands of service beneficiaries along with giving greater focus

towards enhancing beneficiary's experience through higher accommodation in accommodative service orientation. Frei's (2006) analogies exhibit the same considerations put forward by Vargo and Lusch (2004), where the understandings on value cocreation are based on demonstrating a higher degree of responsiveness towards service beneficiaries. This means that a higher degree of service accommodation towards beneficiaries yields higher perceived value cocreation and mutuality (Kandampully et al., 2011; Vargo and Lusch, 2004; Frei, 2006). The firms aiming to achieve service responsiveness and accommodation are seen to put more effort in customizing their services along with showing the higher capability to cater to a broader spectrum of beneficiary's demands. The willingness of a firm to accommodate services begins from a strong TMC to service excellence and finally the presence of a more operant-centric pool of resources. These attributes put together leads to a noticeable higher presence of SDL in organizations (Vargo and Lusch, 2008).

In contrast to accommodative service orientation, a lower TMC towards service excellence and partiality towards operand resources is seen to direct companies towards standardization in their service offerings to achieve overall cost reduction. Reductive service orientation here refers to the aim of organizations attempting to reduce the operating costs and achieve operational economies of scale by offering standardized and automated services (Kandampully et al., 2011; Kimbell, 2011; Frei, 2006). The understanding of reductive service orientation demonstrates the company's aim to prefer service standardization with a lesser focus on individualized services (Frei, 2006). Vargo and Lusch (2004), explaining this notion, have pointed out scenarios where companies fail to cocreate value with service beneficiaries. One factor discussed in their literature refers to the lack of in-depth relationship building with the customers. This coincides with the logic of reductive service orientation where the relationship with beneficiaries holds secondary importance to cost minimization and standardization (Kandampully et al., 2011; Kimbell, 2011). Concludingly, it can be said that the companies exhibiting reductive service orientation rely on operand-centric resources with lower TMC that results in indicating a lower presence of SDL.

2.7.3 MUTUAL VALUE CREATION

The aspect of mutual value creation is extensively discussed in the literature of Vargo and Lusch (2004, 2008, 2015, 2016), however, the scientific community has been observed to enquire regarding the ways this phenomenon could be measured in the real world or backed up by empirical evidence (Krisjanous and Maude, 2014; Hardyman et al., 2015; Grönroos and Helle, 2010). An article by Gronroos and Helle (2010) holds significant value in terms of attempting to provide a solution for the need of empirical evidence enquires, through the introduced model of measuring the 'mutual value creation intensity' (MVCI). Their article brought forward a model that could be used to measure MVCI between service suppliers and service beneficiaries in a value network. The core idea of this model is based on measuring MVC by gauging the intensity of operant resource integration between the dyadic actors in terms of the exchange of operant resources through applicable knowledge and transfer of value-generating skills (Grönroos and Helle, 2010).

Before deliberating further on this concept, it is important to clarify the difference between 'mutual value creation' and 'mutual value cocreation', as pointed out by Vargo and Lusch in 2016 and Gronroos in 2017. Due to multiple confusions originating in the scholarly community, the two authors (Vargo and Lusch, 2015) clarified that ***Mutual Value Creation*** revolves around a dyadic relationship between a service provider and beneficiary and should only be seen as a concept on a micro-level, in order to understand the broader notion of value cocreation. In other words, MVC in marketing is the dyadic relationship, where value is created between the customer and the firm and is shared amongst them simultaneously (Lusch et al., 2007; Ulaga and Eggert, 2006).

Subsequently, the two authors defined ***Value Cocreation*** as 'the exchange of resources between different actors, institutions, institutional arrangements, on a macro level, and most importantly a relationship not confined to a service provider and beneficiary. Further explanation of this concept is reported by the authors as, "*the actions of multiple actors, often unaware of each other, that contribute to each other's wellbeing*". (Vargo and Lusch, 2015). Under the light of this classification, an understanding develops that MVC should be measured (dyadically) in terms of service beneficiary and provider (Grönroos and Helle, 2010) and the value cocreation concept

should be seen in a scope of an entire network of actors, playing their part in a service ecosystem.

The concept of MVC makes it easier for researchers to measure the intensity of value creation in a dyadic relationship, as it is based on a micro-level. On the other hand, it is quite difficult to measure the intensity of mutual value cocreation in larger (macro) settings (Storbacka, 2016) as it involves various actors and empirical evidence in this regard which can be assumed to be impossible (Grönroos, 2017). Furthermore, it has become evident that the concepts of resource orientation, service orientation, and TMC deliberated in the earlier sections all work together to shape MVC amongst all actors in a service ecosystem. Further depth into MVC requires perspectives from both the service provider and beneficiaries as MVC is fundamentally gauged by the level of involvement from both parties.

According to the literature published by Vargo and Lusch (2016), firms are argued to have opportunities that can influence customer's value process, its development, and finally, customer's value fulfilment (Grönroos, 2017). This concept suggests that top management should prioritize designing company services in a manner that keeps in consideration the impact on customers' preferences and their future purchase decisions. Furthermore, the development of this concept enlightens the top management to not constrict themselves on the conventional marketing activities as that would only yield to constructing a brand perception but devoid the firm to embark on the issues of low customer satisfaction and unsatisfactory experiences (Grönroos, 2017). Additionally, having an optimum level of MVC requires the top management to create an organizational atmosphere that encourages market planning, increasing customer satisfaction tactics, building long-term relationships, and planning to generate positive word of mouth (Grönroos, 2017; Hardyman et al., 2015). Another important factor for consideration by the TMC is how to use and offer the resources (resource orientation). Firms that want to mutually create value tend to avoid goods-logic language (Vargo and Lusch, 2016) and plan to gain solid insights into service beneficiaries' goals to enable themselves to reach their targets (Grönroos, 2017). In the light of the studied literature, it has become evident that knowledge transfer amongst service beneficiaries and suppliers is crucial for top management to implement value creation goals. As far as value cocreation is concerned, service providers need to ensure cross-functional coordination and synergy to provide the best

services and resolute value cocreation (Singh and Sharma, 2011). Doing so also increases the overall level of innovation within service providing company (Storbacka, 2016).

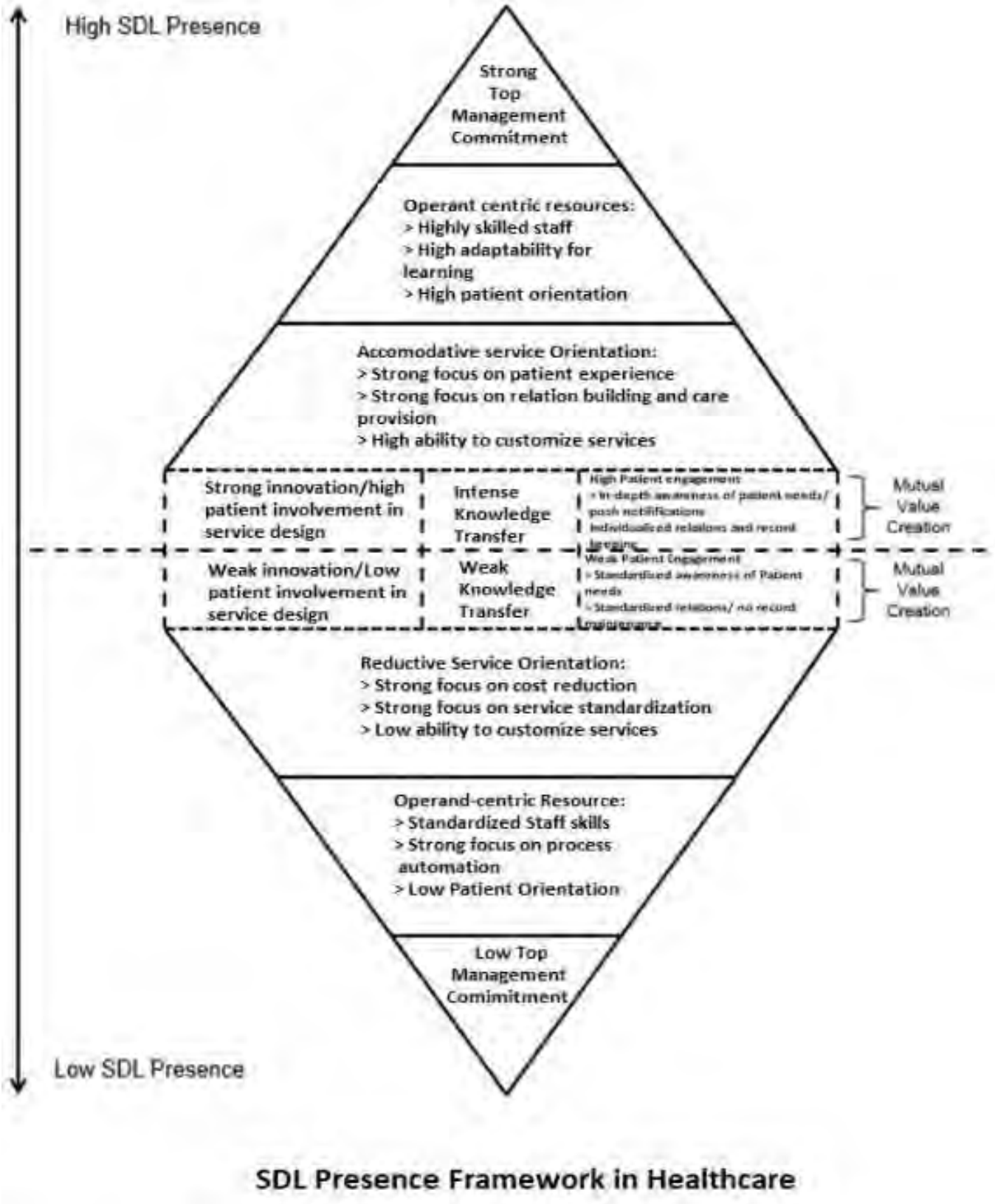
In contrast to service providers, the service beneficiary's level of input in MVC can be determined by the extent of involvement, the customers attain with service suppliers (Kimbell, 2011). As aforementioned, the roles of service beneficiaries require development in terms of exceeding from merely receiving the service (Vargo and Lusch, 2008) to being involved in the service exchange process, knowledge transfer, along with the development and designing of services. A relevant research conducted in healthcare settings talks about the significance of input by patients towards cocreating value with the service provider (Saviano et al., 2010). The crux of this research is based on the same findings that the level of involvement by service beneficiaries provides the therapeutic models satisfactory to both doctor and patient in achieving cocreation of value. Other significant pieces of research in this domain are found to stress the importance of customer involvement in designing services for mutual value creation (Kimbell, 2011; Cipolla and Manzini, 2009; Vargo and Lusch, 2008). As Gronroos (2017) regarded a firm's role to be of a 'value facilitator', the customers automatically are seen to carry a proactive role in the MVC. To carry this role, service beneficiaries are observed as, *the customers who have jobs to be done* (Christensen et al., 2016). Hence the knowledge transfer, in this case, becomes the responsibility of customers, who have to communicate their needs to the service providers. Schultz (2016) is reported to stress this concept by stating that the firms have this responsibility to identify the value customers seek and fill the 'value needs' through effective planning (Schultz, 2016).

From the studied literature, it can be understood that the strength of MVC is based on the inputs by service providers and beneficiaries combinedly. The main constituents of MVC discussed above include relationship orientation, knowledge transfer between suppliers and consumers, and lastly, beneficiary's involvement in service designing. For SDL presence to be perceived high in a firm, it is important that the MVC is articulated and well-established. In contrast to this scenario, a weaker trend towards MVC would deliberate a frailer presence of SDL in an organization.

According to the discussed literature, the SDL presence framework is adapted from another research where the diamond-shaped model was developed to measure the

presence of SDL in business organizations, to collect empirical findings (Maghamis, 2018). However, the original framework by the researcher was constructed to measure the presence of SDL in B2B settings (particularly in a telecommunication setting). The author of this research redesigned this model in a tighter contextualization to healthcare, depicting the needs of a B2P market, which will be discussed extensively in the upcoming section of this literature review. The need to incorporate this conceptual framework in a qualitative (and partially exploratory) research can be best explained by the study of Grant and Osanloo (2014) who discuss the advantages of including conceptual frameworks in dissertations as to how ideas in a study relate to one another. Moreover, the fact that this model has already been tested in a B2B context gives the researcher of this study a new opportunity to explore healthcare market by contextualizing the model to certain requirements. The detailed rationale for the inclusion of this framework is discussed in the methodology section, however, the researcher feels it is pertinent to mention how the adapted model is different to the one the researcher has contextualized to this study.

Figure 2.2, presented below, demonstrates certain elements through which the presence of SDL can be measured in the healthcare clinics of Pakistan. This re-modelled framework is different on the basis that it evaluates patient engagement, patient involvement in service design, and knowledge transfer between the patients and service providers as compared to the original model that evaluates elements of knowledge transfer and service design between B2B organizations. Moreover, the author has kept the focus on the healthcare market which has different requirements, as mentioned in the earlier sections of the literature chapter. On the vertical axis this framework measures the presence of SDL as high or low considering the contextual dynamics of this model i.e., top management commitment, resource orientation, and service orientation. Whereas, on the horizontal axis, this framework evaluates the SDL presence based on the consideration of mutual value creation dynamics i.e., patient involvement in service design, knowledge transfer, and individualization/standardization of services. The model is represented below:



SDL Presence Framework in Healthcare

Figure 2.2: SDL Presence Framework in Healthcare

2.8 KNOWLEDGE GAP

Numerous studies have explored the areas of marketing, management, operations, supply chain, and healthcare with relevance to service dominant logic (Storey and Larbig, 2017; Greenhalgh et al., 2016; Salojärvi et al., 2010). More than a decade of exploration has led to several articles being published expanding the literature on SDL, yet the empirical evidence strengthening its application in practical life has been scarce, if not negligible. The pioneers of this logic themselves are reported to have said that, "*There is still a lot of work to do in reconciling SDL… Through this reconciliation, we see SDL further advancing our understanding of markets and marketing*" (Vargo and Lusch, 2016: 20). As evident from the statement by Vargo and Lusch (2016), SDL is still under development with various key areas currently being explored for empirical evidence, necessary to bridge the theoretical gaps present in this concept.

After reviewing multiple pieces of research, a notable knowledge gap is identified by the researcher in the domain of 'SDL's relevance in the healthcare sector'. The author observed a trend under which most of the literature had its development restricted to the theoretical domain with even fewer studies urging for the need to fill the gap with empirical evidence (Zhang et al., 2015). Additionally, there is a wide gap in studies that can provide empirical evidence to how the patients contribute towards cocreating value (Yan and Kung, 2018; Elg et al., 2013). There is yet to be conclusive empirical data that could suggest that value is indeed cocreated by the service provider and the beneficiary (mutually), in the healthcare settings. Also, the study of the extant literature has been inept to point out if the value is contextual and phenomenologically unique to the relationship (between actors), especially in the healthcare settings.

Further depth into this topic revealed the fact that the majority of the research on SDL is conducted in developed countries and only discusses its relevance in those settings (Angeli and Jaiswal, 2016). The data on SDL in the extant literature (especially on healthcare sector) is scarce and lacks important elements like cultural influence, cost of treatment, and the impact of organizational culture present in the developing countries. This signifies a massive research gap that could shed light on the economies that are based on manufacturing or are agriculture-based. Studying case studies from developing nations may offer novel insight for understanding the

application and relevance of SDL, and awareness for value cocreation in entirely different cultural societies. Furthermore, few studies that do discuss SDL in developing nations (Balarajan et al., 2011; Angeli and Jaiswal, 2016) are seen to lack empirical evidence that could point towards cocreation of value taking place between the service provider and service beneficiary.

Another important factor for consideration is the preferential differences between the patients of developed and developing countries when it comes to availing of healthcare services. The author of this research has observed a massive trend of people preferring private medical treatment in developing countries due to multiple factors that will be discussed extensively in the upcoming sections. Deplorably, there are very few studies that could highlight the implications of SDL in the private healthcare sector of developing nations with the studied outcomes of value creation (micro-level) or value cocreation (macro-level). There seems to be a lack of frameworks or models that could depict the empirical evidence of SDL in private healthcare of the developing states and thus, the researcher aims to fill this gap by conducting case studies in developing countries that will help in bridging the theoretical gap and providing much needed empirical evidence.

Lastly, there has been a continuous debate in the scholarly community regarding healthcare and its relevance with conventional business markets. While many studies regard patients as conventional business customers (McColl-Kennedy et al., 2012), there are numerous researchers that stress patients to belong to a completely different market, with different needs to the conventional consumers (Zhang et al., 2015; Waeen, 2007). The author, under such circumstances, aims to use existing secondary data to fill this gap and construct a model that could conclude if and why the patients are different from the conventional business customers.

2.9 HEALTHCARE AS A SERVICE BUSINESS

Healthcare is defined as the management of illness, treatment, prevention, and the preservation of physical and mental wellbeing through the services offered by the medical, nursing, and allied professions (Costello and Haggart, 2003). Healthcare services are designed to promote health, which includes; “curative, preventive and

palliative interventions, whether directed to individuals or populations" (WHO, 2017). The organized provision of these services may constitute a healthcare system.

Health in the modern age is a complex and sensitive issue. Once only in the hands of practitioners, healthcare now includes the central role of political setups and socio-economic agencies (Waeen, 2007). Many scholars have reported this change in their studies, for example, Zhang et al (2015) described that the way healthcare is seen in today's world is quite different from how it has been considered in the twentieth century. Gray (1983) reported it as a change in the medical world from 'social profit' to 'for-profit' organizations. The author stressed that 'social profit' institutions have been more typical of the organizations that provide medical services to the patients, whereas 'for-profit' firms represent more of a shift towards the business side of this sector. He is reported to have said that:

"With little initial public notice, a vigorous and varied for-profit sector has developed in the predominantly not-for-profit world of medical care. Health services are now being provided by thousands of for-profit organizations… (Gray, 1983: 01)".

Moreover, the change from providing 'social profit' to the community, to becoming a 'services business' shows how the dynamics of healthcare have changed, along with the roles of service providers (Gray, 1983; Mankiw, 2017). The scientific community has documented much evidence regarding how the world has shifted towards recognizing the significance of the service sector and how healthcare is seen as a service business that runs on similar principles as of a consumer market (Mankiw, 2017). The example of the US and other developed economies in the world portrays how a profession of medicine has amalgamated in the healthcare business and is working towards the prioritization of capturing patient value (Gandolf, 2020). Joiner and Lusch (2019) emphasized the same findings, stressing how the term *healthcare* had a different meaning in the past and was more based on the principles of goods-dominant logic than as a services business in this age and time. The new understanding of the term 'healthcare' can thus be understood from the statement that summarizes the observed change:

Healing is an art, medicine is a profession, but healthcare is a business. (Gandolf, 2020)

The drivers of change can be noticed from the recent marketing of services that view consumers as ‘actors’, essential for the cocreation of value (Vargo and Lusch, 2019). Moreover, factors like; focus on wellness care, patient-centered care, patient engagement, and personalized medicine, show how healthcare institutions are prioritizing capturing patient value with end goals of conducting successful business practices (Joiner and Lusch, 2019). The belief that healthcare providers who view healthcare as a service ecosystem tend to design better health delivery’s value proposition for the consumer, shows how crucial delivery of services has become in the healthcare sector (Zhang et al., 2015). This brings us to the understanding that healthcare can be regarded as a service business that operates on the factors such as, innovation, service quality, service delivery, and customer satisfaction.

The discussed change of healthcare perspective brings many questions as to how the future of the healthcare sector will be viewed globally and the ambiguity to recognize patients as a consumer of traditional consumer market or consumers with special needs.

2.10 HOW HEALTHCARE IS DIFFERENT FROM CONVENTIONAL MARKETS?

It is often debated in the scholarly community whether patients could be compared to business customers or not. Taking a look into the standard theory of markets, the model of supply and demand can be noticed where sellers and purchasers are directed by the prices to an efficient allocation of resources. However, this concept deviates from the model of healthcare where the deviations (for example) can be guided by the government policies, to safeguard that the healthcare resources are allocated efficiently and effectively (Mankiw, 2017). In most cases of the traditional markets, the consumers are aware of their needs and wants (McColl-Kennedy et al., 2012) and they are in a position to judge if they are happy with the transactions upon completion.

However, the studies that regard patients as being different from business customers reason on the basis that the ‘status’ of patients is greatly impacted by illness or injury that renders them vulnerable, frightened, often in pain, medicated, exhausted, and confused (Torpie, 2014). According to Zhang et al. (2015) customers of healthcare

often have conflicting goals as compared to business customers which include accessibility, trust, quality of life, convenience, and safety. Henceforth, healthcare is argued to be different from the traditional market in a way that the consumer might not know about the best treatment upon getting sick (Mechanic and Meyer, 2000; Mankiw, 2017; Prahald and Ramaswamy, 2000; Nordgren, 2013). Moreover, The patients rely upon the advice of a GP, who has years of experience in diagnosing and treating illnesses (Mankiw, 2017). Further to this argument, the consumers cannot reliably judge if the offered treatment by the practitioner is the right one for them and hence, by this logic, relating patients to traditional business customers do not fit in the standard business model.

Alternatively, some researchers argue that patients are similar (if not the same) to business customers (Lubeck et al., 2000a; Marcinowicz et al., 2009). One argument stresses that patients experience the quality of services provided (Lubeck et al., 2000) and are affected by service satisfaction or dissatisfaction levels just as any business customer. Due to expecting service innovation for better value perception and co-creation, the patients tend to show almost ‘similar’ traits to any business customers (McColl-Kennedy et al., 2012). Further arguments from the researchers suggest that the ‘goods’ that patients purchase could be regarded as a return to health and the ‘services’ they pursue could be seen as additional components which include; trust, safety, and convenience (Mechanic and Meyer, 2000). Moreover, patients play a significant role as evaluators of healthcare, and most of the time they help to develop more customer-centered approaches to healthcare delivery via their feedback (Marcinowicz et al., 2009). Henceforth, the conceptual lens of these researchers deems it unnecessary to class patients differently from a traditional notion of the market.

In the light of the above-mentioned arguments, the obvious factor is that patients have been typically been viewed as having a passive role, in other words, merely a recipient of the offerings of organizations (Payne et al., 2008). The view on perceiving patients as ‘business customers’ or as a completely ‘niche’ market changed with recent studies providing insights into the healthcare customer practices (McColl-Kennedy et al., 2012; Vargo and Lusch, 2015; Osei-Frimpong et al., 2018). These new studies viewed patients as ‘actors’ who are active in co-producing the service along with healthcare

professionals (Osei-Frimpong et al., 2018). This means that the patients have an active role in contributing personal resources such as information and technology, by engaging in a variety of activities by themselves and with others to improve their health and wellbeing (McColl-Kennedy et al., 2012). The existing argument about 'patients not knowing the outcome of their treatments' was also challenged by the new studies that contended on the introduction of new services such as 'e-service', where patients have greater access to knowledge and almost full understanding of their illness with the knowledge of activities that could be performed by them to improve their health outcomes (Topol, 2015; Tian et al., 2014).

The understanding of recently conducted studies portrays a pattern where a large percentage of the scholarly community is agreeing to an active role of the patients, influencing the services they receive from the service providers, and exchanging competencies throughout the overall process. As this information provides overlapping characteristics of a patient and conventional business consumer, a new classification is necessary to understand what market the healthcare consumers belong to. This understanding goes in line with the fundamentals of Service Dominant logic (Vargo and Lusch, 2004; Joiner and Lusch, 2016) and opens avenues for the research that has been conducted in the field of healthcare for a better understanding.

To understand which market the customers of healthcare belong to, the author of this research explored various pieces of literature that demonstrate findings on the same/similar subject (Ojasalo, 2001; Torpie, 2014; Zhang et al., 2015; Mechanic and Meyer, 2000; Khowaja, 2009). The study of literature highlighted 4 major aspects from which the difference between a 'business to customer' (B2C) market and a 'business to patient' (B2P) market could be analyzed. The four aspects are as followed:

1. Psychological orientation of consumer
2. Will to avail/purchase the service
3. Buying Options and
4. Overall Experience

Main source of identification of the said aspects is presented in Table 2.6:

MODEL ASPECT	ELEMENT	STUDIES
PSYCHOLOGICAL ORIENTATION	Excitement Orientation	(McColl-Kennedy et al., 2012) (Lubeck et al., 2000b) (Belk, 1992) (Hebdige, 1979)
	Anxiety Orientation	(Torpie, 2014) (Zhang et al., 2015) (Mechanic and Meyer, 2000) (Marcinowicz et al., 2009)
WILL	Free Will	(Hagel and Singer, 1999) (Topol, 2015) (Tian et al., 2014) (Vargo and Lusch, 2004)
	Tethered Will	(Mechanic and Meyer, 2000) (Mankiw, 2017) (Nordgren, 2013) (Prahald and Ramaswamy, 2000)
OPTIONS	Unlimited Options	(Achrol and Kotler, 1999) (Ojasalo, 2001) (Ranaweera, 2003) (Lusch, 2019)
	Limited Options	(Khowaja, 2009) (Balarajan et al., 2011) (Angeli and Jaiswal, 2016) (Marcinowicz et al., 2009) (Yan and Kung, 2018)
BASELINE	Adding To Baseline	(Hagel and Singer, 1999) (Robert F Lusch, 2019) (Ojasalo, 2001) (Schlesinger and Heskett, 1991)
	Return To Baseline	(Hiatt, 1975) (Hardyman et al., 2015) (Elg et al., 2013)

Table 2.6: Sources used for differentiating B2P and B2C market

A step-by-step explanation of the mentioned aspects is necessary to understand the reasoning behind a 'B2P' market for the customers of healthcare:

Psychological Orientation: An important factor in understanding the need for a separate market for patients can be analyzed by the psychological orientation that conventional business customers and the patients' exhibit. Belk (1992) explains the element of 'excitement' when discussing the behavior of business customers, along with the feeling of 'happiness' achieved by them during/after the purchase of a product or service. Hebdige (1979) stresses a similar finding by explaining the decisional patterns of business customers and the presence of a 'positive lens' through which customers make purchases from the businesses. Recent literature has also pointed

out the psychological orientation of conventional business consumers, as explained by Belk (1992) and Hebdige (1979), stressing the positive mindset of customers who are happy to make the purchases, or who become happy after making the purchase (Lubeck et al., 2000b; McColl-Kennedy et al., 2012). From the gathered evidence it is observed that conventional consumers tend to make decisions based on a positive lens, which means that; elements like happiness, excitement, and wants of consumers lead to the purchase of a service. This mindset can thus be seen as '**Excitement Orientation'**, associated with all the business customers in a market.

Contrastingly, patients exhibit more of an '**Anxiety orientation'** that is backed up by anxiety and suffering which leads to the purchases and is often viewed through a negative lens. This concept can be understood from the study of Torpie (2014), who describes that patients are in a situation where the purchase of a healthcare service is not leading to happiness, rather, these purchases are being made due to the anxiety that follows after an illness, disease or other health problems. Other researchers have also presented their findings which stress that the healthcare purchases of patients portray a negative lens or a psychological state, where 'getting rid' of anxiety is the reason to avail healthcare service/s (Zhang et al., 2015; Mechanic and Meyer, 2000; Marcinowicz et al., 2009).

Will to Avail/Purchase: Moving forward, the concept of '**Free Will**' can be observed for the conventional consumers, who purchase the services without any pressure and exhibit patterns to 'avoid' a purchase if the options are unsuitable or simply 'limited to one' (Hagel and Singer, 1999). This understanding is based on conventional business markets that are saturated with competition and contain various products and services for the customers to choose from. There is no pressure on the customers to make a purchase against their will and they can choose a product or service based on their preferences (Tian et al., 2014; Lusch, 2019).

Patients, on the other hand, see themselves in situations where they are left with no option or free will to pick, choose or deny services as easily as conventional consumers (Mankiw, 2017; Nordgren, 2013). Situations of healthcare customers make them avail any available service as 'not getting better' is not an option for them (Mechanic and Meyer, 2000). Due to the characteristics that patients exhibit in this domain, these customers of healthcare can be classified as the ones having a

‘**Tethered Will’**.

Buying Options: Moving on to the ease of buying options, B2C customers have the option to choose amongst different competitors for the best service or product to satisfy their needs and wants (Achrol and Kotler, 1999). The additional element like; access to information, makes it easy for these consumers to evaluate and choose between the competing providers (Ranaweera and Neely, 2013; Ranaweera, 2003). For B2P customers, constraints like; being limited to the local GP/hospital, make it difficult to avail any other option (Balarajan et al., 2011). The example can be taken from emergent cases where the patients lack time, information (or both) to decide regarding any alternative option and they have to act fast to utilize the most available healthcare service/s (Yan and Kung, 2018).

Overall Experience: Lastly, understanding the overall experience of the customers according to their psychological point of view is one of the most important factors for characterizing them into a specific market segment (Hagel and Singer, 1999). Studies by Hagel and Singer (1999) and Schlesinger and Heskett (1991) introduced a concept of a ‘baseline’ for customers. These studies suggested that a purchase by B2C customers can be seen as an addition to their experience, starting from a baseline (Schlesinger and Heskett, 1991). The authors stressed that the ‘wants’ of business customers represent their desires to move away from the current situation/s they see themselves in. Moving further away from that starting point (baseline) can be seen as the aim of business customers that is attained through gaining positive experience and satisfaction by making business purchases.

In contrast, B2P customers seek to return to the baseline with their purchases, which for them is the previous state of being healthy (Elg et al., 2013). This can be understood by the fact that the baseline for the patients is being healthy (starting point). In case of an illness or disease, the patients see themselves moving away from the baseline and thus, their aim is to return to the baseline and achieve the state of optimum health (Elg et al., 2013). Furthermore, in this case, returning to the baseline is not guaranteed (Hardyman et al., 2015), yet the patients are seen to be compelled by their health-related concerns to make the purchases. This concept of **adding to baseline** and **returning to baseline** makes business customers and patients dissimilar to one another and hence, cannot be placed into the same market segment.

The author of this research has formulated a table from the gathered evidence which makes it clear that healthcare institutions serve patients under the category of the B2P market rather than the conventional B2C one. The table demonstrated below talks about various factors that classify patients as healthcare consumers with special needs and orientation. The table is presented below:

B2C MARKET	B2P MARKET
EXCITEMENT ORIENTATION B2C customers view decisions through a positive lens. For example: Excitement and happiness leads to purchases.	**ANXIETY ORIENTATION** In B2P market the decisions are viewed through negative lens. For example, decreasing anxiety and suffering leads to purchases.
FREE WILL B2C customers have the ability to choose between different options without much pressure. Even when limited to one option, the customers can choose to avoid it.	**TETHERED WILL** B2P customers are forced by 'situation' to make a choice. 'Not getting better' is no option for these customers.
UNLIMITED OPTIONS These consumers have the option to choose amongst many competitors. They usually have access to information in order to help them compare between multiple options.	**LIMITED OPTIONS** Patients are usually limited to local GPs or hospitals. In most cases, patients lack time, information (or both) to make decisions.
ADDING TO BASELINE These customers start from a baseline and each purchase adds to that experience.	**RETURN TO BASELINE** Patients seek to return to the baseline (which may or may not be guaranteed).

Table 2.7: Demonstrating differences between a B2C and B2P market

2.11 SDL AND HEALTHCARE

SDL has gained a lot of popularity since 2004 with researches abundantly focusing on the impact of SDL on healthcare (McColl-Kennedy et al., 2012). One of the major changes that occurred in the healthcare sector is; how a patient is seen under this new theoretical lens (Joiner and Lusch, 2016). The occurrence of displacement with time shifted the belief which saw patients being the recipients of a service provided by the producer, through being a participator of the creation of value in service experience (Bitner et al., 2013), to being an actor who cocreates value (Vargo et. al., 2008; Nordgren, 2013). This concept is aligned with the second axiom of S-D logic (Vargo and Lusch, 2015) which states that;

"Value is co-created by multiple actors, always including the beneficiary"

The role of 'SDL in healthcare' helps to understand how patients can co-create value (Vargo and Lusch, 2016) to better manage their health and to provide value for service healthcare firms such as clinics, hospitals, and governments (Lubeck et. al, 2000). As value cocreation and SDL in healthcare has gained much attention in the past few years (Krisjanous and Maude, 2014), the major reason behind this devotion can be understood by the demands of active 'patient participation' in healthcare experiences, instead of the (predominant belief) where patients were seen as passively conforming to the healthcare professionals' commendations (Yan and Kung, 2018). The author of this study has come across various researches which focus on customers' participation in the 'shared decision making' process and argue on the positives of such practices in yielding; improved psychological wellbeing, medical status, and superior level of satisfaction of the patients with general practitioners (Patrício et al., 2018; Freire and Sangiorgy, 2010; Saviano et al., 2010). Following this literature, an interesting avenue is seen to build where the in-depth understanding of 'active participation by patients', becomes crucial to validate the arguments presented by the researchers.

To understand what counts as 'active participation', the study by McColl-Kennedy et al. (2012) can be seen as a pioneering input that deliberated on the activities that patients engage in, to cocreate value with the healthcare professionals. The findings from the research by Sweeney et al (2015) have also been observed to affirm McColl's hypothesis that, from the SDL perspective, the individuals can engage in activities that

have the potential to improve their quality of life and cocreate value with healthcare professionals. The 3 sets of activities presented in the research by McColl-Kennedy (2012: 04) include:

a) *Self-generated activities, that include 'cerebral activities, including "self-talk," "being philosophical," "reframing and sense-making," and "psyching myself up"*
b) *Private sources include friends and family, while market-facing sources may include other entities and firms*
c) *Public sources may include community groups, programs, and government departments*

For cocreation of value to occur, Vargo and Lusch (2004, 2008, 2015) have repeatedly argued on the significance of the integration of resources and collective efforts from all the actors in a service ecosystem. A similar stance is observed in the above-mentioned 'patient-activities' where multiple actors can be noticed as integrating resources and collectively contributing to the welfare of patients (Zhang et al., 2015). Further in-depth research suggests that 'self-generated activities', in this regard, can be referred to as positive thinking, co-designing, and analyzing the problems through the patients' end, which in turn can prove beneficial for the healthcare providers to treat those patients. It is found to be well established in the literature that cocreation of value is greatly achieved when patients engage in designing healthcare services (Patrício et al., 2018; Freire and Sangiorgy, 2010). Furthermore, the authors are observed to argue that co-designing is a secondary step that originates when the patients 'try to make sense', 'reframe' and consequently help practitioners with their feedback, suggestions, and proposals. Also, this statement refers to the improvement in quality of life, where patients engage in 'preventive approaches' that can lead to a healthier lifestyle. Yan and Kung (2018) argue in their article that half of the responsibility lies with the patients to mutually cocreate value, for example, by avoiding certain diets/activities as advised by the medical professionals.

As the literature on value cocreation focuses on the macro relationship between all the actors (instead of firm and patient dyad) (Grönroos, 2017), patients are seen to engage in activities with their friends and family that can lead to improvement in their quality of life and the overall health outcome. This concept can be understood as a result of an emotional influence or professional advice from someone that the patient trusts (Osei-Frimpong et al., 2018). Comparing this information with the findings of McColl-

Kennedy et al. (2012), an understanding develops that these activities lead to shaping the patient's cognitive pattern and can help in cocreating value with the healthcare professionals (Marcinowicz et al., 2009; Lubeck et al., 2000b). Again, the research findings by McColl-Kennedy (2012) are seen to be coherent with studies discussing 'market-facing sources' that can include doctors, nurses, personal trainers, etc. This scenario depicts direct value creation with the healthcare providers through high collaboration (Saviano et al., 2010), sharing of knowledge (Laver and Croxon, 2015), etc. Additionally, the application of SDL is seen to encourage patient engagement, feedback, and participation in relatively direct service provision activities, such as self-service, service design, and new service development (Sweeney et. al., 2015). The concept of self-service and providing new service ideas to service providers such as; reduction of waiting time in hospitals/clinics and reconfiguring the composition of the medical team, including "hiring" and "firing" of doctors not only helps in achievement of a better service delivery structure but also incorporates patients as the 'co-creators of value' (Leatherman et al., 2018). The third example is mainly focused on public sources through which patients may engage in value cocreation activities and can demonstrate an active participating role. The authors gave an example of pragmatic adapting through which the patients can be seen to adapt to the circumstance and cocreate value (McColl-Kennedy et al., 2012). This scenario can be best explained with the example that a cancer patient might change their job to accommodate his/her health situation based on the support from a cancer support group. This example highlights that joining the support group is an act of 'active participation' by the patient, community groups and departments can 'act' towards cocreating value, and that patients are equally important in contributing towards value creation (Greenhalgh et al., 2016).

Moving forward, the research by Yan and Kung (2018) acknowledged the hypothesis of McColl-Kennedy et al (2012) by their findings that the interactions/engaging activities between doctors and patients do seem to help achieve cocreation of value in the field of medicine and healthcare. Their research focused on the implication of SDL in healthcare which was found to yield a better understanding of 'input, process and output' in medical services along with cocreation of value amongst the various actors in a service ecosystem. The role of patients was found to be 'active' in healthcare, helping to promote the quality of medical services, and consequently enhancing the quality of life of the patients (Joiner and Lusch, 2016; Bitner et al.,

2013). From the research findings of Yan and Kung (2018), Joiner and Lusch (2016), Bitner et al (2013), and McColl-Kennedy et al (2012) it can be seen that all authors agree on the involvement of health consumers in the value creation process, which is an essential tenet of SDL (Vargo and Lusch, 2016). As SDL argues that value is always determined by the beneficiary, this becomes relevant to the healthcare sector where the patients determine the type of value that they seek (Zainuddin et al., 2013).

Although the above-mentioned literature point towards the benefits of managing and observing healthcare under the SDL conceptual lens, the practicality of SDL in the real world is still complex and comes with numerous challenges. It is observed that the stakeholders often have conflicting goals that can include trust, safety, accessibility, convenience, and communication (McColl-Kennedy et al., 2012). Moreover, reduced patient throughput times and lesser costs can no longer fully exemplify the value of healthcare services (Osei-Frimpong et al., 2018). There is a wide gap in studies that can provide empirical evidence to how the patients contribute towards cocreating value (Yan and Kung, 2018). Research by Elg et al (2013) argued regarding this same issue, questioning how healthcare providers can develop services based on the patient perspective and how the current model of healthcare can be improved by learning from the patient's input (Elg et al., 2013). Elg and his colleagues did come up with an experimental value cocreation model that could help healthcare providers to learn from the patients, however, the focus on collecting and providing feedback to the patients was missing in their research. As value cocreation involves the exchange of knowledge from all actors (Vargo and Lusch, 2004), such approaches in the practical world do become a very complex phenomenon.

Due to the multi-faceted nature of value cocreation, it can be understood that it is a complex process that cannot be perceived to be linear because of the wide range of service providers having various skills, competencies, and roles in healthcare (Hardyman et al., 2015). Subsequently, the exact understanding of how the patients act to cocreate value in healthcare brings up questions regarding the conceptual lens of SDL and its applicability in healthcare (McColl-Kennedy et al., 2012; Elg et al., 2013). To answer the uncertainties regarding the concept of value cocreation and SDL in healthcare, Joiner and Lusch (2016) came up with assertions in their article to how this concept can be seen from the service providers' and consumers' point of view. One argument reflected that by alleviating patients' deliberate reflection on their

wellbeing, the healthcare consumers might be encouraged to engage in positive health behaviors (leading to value cocreation). Another example of the research by Yi and Gong (2013) was presented which suggests that customers naturally participate in value cocreation by seeking or sharing information and by developing strong interpersonal skills (Yi and Gong, 2013). Overall, the focus of the argument by Joiner and Lusch (2016) was based on engaging healthcare consumers in the critical reflection of their health statuses to engage them in the value cocreation process/es. Although the research by Joiner and Lusch (2016) lacked empirical evidence to back their arguments, another study in 2019 revealed that integrated care experience is undoubtedly the cocreation of value (in healthcare settings), which includes ethical and emotional aspects, contributing to the service outcome (Vespestad and Clancy, 2019). The overall impact of the introduction of SDL in healthcare settings can thus be seen as an increased interest towards supporting patient participation in value cocreation to transform healthcare delivery and positively affect consumer's wellbeing (Anderson and Ostrom, 2015).

From the studies literature it can be seen that numerous researches have examined the role of SDL and value cocreation in healthcare delivery for example; (Elg et al., 2013; McColl-Kennedy et al., 2012; Payne et al., 2008; Osei-Frimpong et al., 2018; Joiner and Lusch, 2016; Hardyman et al., 2014; Zainuddin et al., 2013; Bitner et al., 2013; Nordgren, 2013). Unfortunately, studies lack a strong understanding of how the vital individual factors like; (Trust, belief, and interactions on the patient level; and social skills, assurances, and doctor-patient orientation) at the doctor level play out in healthcare service engagement from a dyadic standpoint leading to value cocreation (Vespestad and Clancy, 2019; Osei-Frimpong et al., 2018). Moreover, there is a huge gap in the empirical evidence to how patients participate in cocreating value in the healthcare settings (McColl-Kennedy et al., 2012). Hardyman (2015) has argued for more research of an *ethnographic nature* on how value is cocreated in healthcare based on the patient value cocreation practice styles proposed by McColl-Kennedy et al (2012). For this particular reason, the author of this study is going to examine cocreation practice styles of patients in both developing and developed countries across the globe.

2.12 COMPARISON OF HEALTHCARE IN DEVELOPED AND DEVELOPING COUNTRIES

Developed countries differ from the developing states in a variety of ways which include; social, cultural, financial, and institutional factors (Angeli and Jaiswal, 2016). The figures obtained from World Bank represent a higher 'healthcare spending' trend for developed countries as opposed to the developing states (WorldBank, 2020). Examples in this regard are the United States, United Kingdom, Norway, Germany, Sweden, and New Zealand, where overall healthcare provision is deemed satisfactory and healthcare expenditure per GDP is recorded to be higher than many developing nations (WorldBank, 2020). The presence of strong public healthcare governing bodies helps states to provide standard quality of services to the masses. Also, studies conducted in these countries imply that (almost) all the residents are provided with equal access to healthcare and the quality of services is homogenous due to the presence of centralized and/or de-centralized healthcare systems (Nordgren, 2013). Examples of NHS (UK), Medicare (Australia), and NHS (Norway) can be seen in this regard, where government expenditure on healthcare (per GDP) is high and consequently, the healthcare systems are considered to be in the top 10 systems of the world (Schneider et al., 2017). A stable political system, adequate funding, strict check and balance are some of the reasons why healthcare services are observed to be adequate in developed countries (Schneider et al., 2017).

Another important factor while discussing developed countries is the type and percentage of the economy that accounts for the annual GDP. Studies have shown that developed countries account for a higher percentage of the services sector than developing ones (WorldBank, 2020). An example in this regard can be taken from Germany, where 70% of the annual GDP contribution comes directly from the services sector (IMF, 2019). It is due to this trend that 'services' have become a point of interest for the researchers, and concludingly, led to the investigation by Vargo and Lusch in 2004 to understand and interpret the concept of service dominant logic.

Due to a higher prevalence of the service sector (as opposed to manufacturing), several developed countries are involved in understanding the significance, value, and delivery of 'services' to improve their economies (Waeen, 2007). Moreover, the author of this study has come across various pieces of literature on 'SDL in healthcare

settings' from the countries such as Norway, the US, UK, Sweden, and Germany (Joiner and Lusch, 2016; Nordgren, 2013) which signifies the trend of researchers (based in developed countries) focusing on services as a fundamental basis of exchange. This observation goes in line with the conceptual lens introduced by Vargo and Lusch (2004) and paves a way to understand services in context to the first axiom of the published article.

When it comes to the second axiom of SDL, the role of multiple actors in cocreating value is a phenomenon that is being widely researched in developed countries for the improvement of service delivery (Joiner and Lusch, 2016). Examples in this regard are; a research by Vespestad and Clancy (2018), that talks about the second axiom of SDL concerning developed countries. The study conducted by these researchers focused on the role of SDL in primary care settings (Norway) and discussed how collaboration between healthcare actors can mutually cocreate value in primary healthcare settings. Another research by Bierao et al (2017) discusses the role of cocreation in healthcare settings by emphasizing the integration of resources amongst actors and cocreating value with the beneficiary (Beirão et al., 2017). Also, the articles focusing on patient feedback and MVC from the beneficiary's end have already gained popularity (Zhang et al., 2015; Zeelenberg and Pieters, 2004; Yang et al., 2015) in the developed countries and more researches are being conducted to collect an adequate amount of empirical findings to strengthen the concept of service dominant logic and the role of multiple actors in cocreating value. By examining the overall trend of studies conducted in these countries, it is seen that scholars are already on their way to exploring and finding empirical evidence that could conclude how multiple actors cocreate value with the beneficiary.

A current model of NHS (UK) can be observed to understand the third axiom of SDL and its role in the developed countries. The emergency department of NHS (UK) uses an online healthcare system through which the doctors, nurses, pharmacists, and patients are seen to exchange resources for better value creation (NHS, 2020). The exchange of knowledge and skills can not only be seen as effective integration of resources but also a good example of the change in the focus towards the use of operant resources. Healthcare systems in developed countries have realized that value creation is only possible when the resources are integrated amongst various

actors (Vespestad and Clancy, 2019). The exchange of experience, specialized skills, and competencies amongst pharmacists and doctors is enabling the healthcare individuals to better identify and resolve the problems (diseases). Patients on the other hand are considered as a vital source of improvement in the current models due to their feedback and active participation in the overall healthcare process. It is also observed that the use of IT, surveys, feedback, and collaboration is helping the healthcare systems to integrate resources and collaborate during the whole process of healthcare provision.

Regarding the fourth axiom of SDL i.e., Value is always uniquely and phenomenologically determined by the beneficiary, much has already been discussed in this chapter to how the focus of developed countries has changed towards accepting the service beneficiaries as determinators of value. Examples like; health enhancement, consumer-value selection, and health investment can be seen in this regard which is believed to be the analogous shift for the language describing value creation between provider and the patient (Joiner and Lusch, 2016). 'Rate the service received' text messages from the NHS (UK), after visiting a hospital, GP, or dental clinic, are some of the examples where value is being determined by the feedback received from the beneficiary. Further research suggests that the customers in developed countries actively engage in value cocreation by the means of feedback, involvement in service design, and intense knowledge transfer (Joiner and Lusch, 2016; Vespestad and Clancy, 2019; Osei-Frimpong et al., 2018). More research is underway to realize how patients determine value in healthcare settings of developed countries and academics are pointing out the need for empirical evidence to strengthen the conceptual logic of SDL.

Overview of the fifth axiom of SDL can be understood by an article by Ng and Vargo (2018) which addresses the importance of actor-generated institutions in healthcare settings by proposing a typology of institutions enabling or constricting consumer centricity and value cocreation in service ecosystems. Nine types of institutions, that are identified and illustrated in the research include culture, structure, process, metrics, language, practices, intellectual property (IP), legislation, and general beliefs. The examples are taken from a healthcare context (in developed countries) which provides case study evidence to how pharmaceutical companies react and induce

institutional change (Ng and Vargo, 2018). As explained in the article by Vargo and Lusch (2015), there is still a lot of empirical ground that needs to be covered for institutional theory but at its core, the theory sees the actors to form, reform, and be influenced by the endogenously generated structures (institutions) that support their joint survival.

A deep understanding of the service structure, institutional system, healthcare markets, value perception, and cultural context is necessary to evaluate the role of SDL in the healthcare sector of developing countries.

Past researches claim that the people residing in developing countries have less access to healthcare as opposed to the developed ones, and inside those developing countries, the poor have less access to healthcare as compared to the rich (Peters et al., 2008). When it comes to the quality of healthcare provided in those countries, it is observed that the appropriateness for resource-poor settings has received little attention, and improvement in quality healthcare remains sporadic in developing states (Leatherman et al., 2018). Many measures have been taken to overcome this issue including; WHOs Framework for Action (2007), Millennium Development Goals (MDGs), and Alma Ata Declaration to help developing countries provide basic healthcare to individuals residing in the respective countries (WorldBank, 2018; Leatherman et al., 2018; O'Donnell, 2007), but the progress recorded in the third world countries is still far from the desired goals (WHO, 2021).

In today's world, the first thought that comes to mind while discussing healthcare in developing countries is, "the under-optimal access of disenfranchised individuals in economic resource-poor areas of the worlds" (Angeli and Jaiswal, 2016). This statement explains the condition of the majority of the individuals living under/on the poverty line in the developing countries, and can be characterized as people having; limited health access, enhanced exposure to disease-prone environments, poor living conditions that contribute to poverty, lower life expectancy and depleted quality of life (Marmot et al., 2008). Although, being able to obtain quality healthcare is a birthright of every individual regardless of their race or nationality (Bazelon, 1969), but effective healthcare provision is a big problem for developing countries as they are constrained due to economic, social, and political factors. World Bank and WHO released figures in 2015 stating that an estimated 400 million people lack basic healthcare services

globally, with a major chunk comprised in developing states (Usher et al., 2015). For this very purpose, World Health Organization came up with a strategy in the 1990s to improve planning, development, execution, and financing of health policy to help construct fair financing of a decentralized health system worldwide (UN-Pakistan, 2020).

When it comes to the 'healthcare markets' in developing countries, it can be observed through the institutional theory lens that these markets differ remarkably from the higher tier markets (Angeli and Jaiswal, 2016; Shaikh et al., 2017). Also, evident from various pieces of literature is the understanding that economic-resource-poor communities are considered by their institutional isolation and an idiosyncratic structure of beliefs, socio-cultural traditions, values, and norms (Rivera-Santos et al., 2012; Angeli and Jaiswal, 2016). These informal institutions in turn have a dominant role in governing social life in these contexts (Khursheed et al., 2015). The institutional divide that exists between developing and developed healthcare markets demonstrates different meanings and values attached to the products and services (Angeli and Jaiswal, 2016; Rivera-Santos et al., 2012).

The fact that quality perceptions have a strong influence on patients to avail services is beyond dispute, hence, the people living in developing countries are seen to be more attracted towards private treatment (Angeli and Jaiswal, 2016). There are multiple factors due to which the provision of quality public healthcare in developing countries is observed to be unsatisfactory with some common factors like; financial constraints, political instability, and lack of formal institutions (Angeli and Jaiswal, 2016; Khursheed et al., 2015; Kumar et al., 2008; Shaikh, 2015). Worsening of country's economic conditions and democratic instability is considered to be the major cause of the escalation to this percentage (Aljunid, 1995; Khursheed et al., 2015) as more and more patients prefer private healthcare resulting in an increased workload on private practice (Malik and Syed, 2012).

2.13 INTRODUCTION TO THE HEALTHCARE SYSTEM OF PAKISTAN

Pakistan is ranked as sixth most populated country in the world (worldometers, 2021), and being one of the developing states, yields a huge number of cases requiring proper medical attention daily (Anwar et al., 2012). Due to soaring population in the country, high number of diseases are reported thus demanding increased medical treatment for the citizens (Malik, 2015). To cater to the medical needs of the country, Ministry of Health in Pakistan makes policies and strategies at the Federal level of governance (Anwar et al., 2015). Therefore, Medical Association of Pakistan is divided into 2 main sectors i.e., Public and Private sector. Public sector in Pakistan comes under the control of government, consisting of basic health units, hospitals and dispensaries whereas private sector usually incorporates general practitioners providing their services in 'private medical clinics' (Anwar et al., 2015). As cited by many researchers, private sector in Pakistan also includes unregulated practitioners, homeopaths, herbalists, hakeems and healers etc. (Shaikh & Hatcher, 2004). Although these unregulated practitioners are unreliable, they are active and successful in majority of rural and urban areas of Pakistan (Khowaja, 2009). For credible findings of this research, author will only focus on regulated private practice in Pakistan with certified general practitioners. The downfall of economic growth in the previous years (Worldbank, 2017) and democratic instability have led to poor performance of government-based institutions including the healthcare sector (Khursheed et al.,2015). A research conducted by Anwar et al (2012), characterized Pakistan's healthcare as a system comprised of insufficient expenditure, poor excess to-and- utilization of services, and poor quality of overall services. Due to such a scenario healthcare system of the country has become dependent on external aid to cater to the ever-increasing medical needs of citizens (WHO, 2020).

A huge gap that exists between actual health spending (Public health sector) of many developing states and the required spending for critical health services proposes that the lack of availability is the root cause in the majority of occasions (O'Donnell, 2007). Also, the under-utilization of health services in public sector has been reported for being almost a universal phenomenon in developing countries (WHO, 2021). The same is the scenario with the given example of Pakistan, where catering to the medical

needs of the entire population of the country, the Ministry of Health (MOH) develops the National policies and strategies at the Federal level with a small chunk of the allotted budget. The poorly funded policies are made for the under-served which includes maternal healthcare and all emergent or non-emergent needs (Anwar et al., 2012).

Coming to the social and cultural factors in Pakistan, an intervention can be observed regarding the health-related behavior pattern of the patients. It is observed that family constraints, potential stigma, gender, and uncertainty regarding modern healthcare infrastructure are some of the common factors that differentiate the consumers of developing countries from the developed ones (Kumar et al., 2008). Health-seeking behavior in developing countries (for instance Pakistan) is often seen to be undermined due to the strong influence on socio-cultural beliefs and values (Shaikh, 2015; Khursheed et al., 2015), particularly for the women (Angeli and Jaiswal, 2016). The example of this behavior can be seen with the trend of patients often visiting unqualified traditional healers as their first consultation point rather than the licensed GPs (Khursheed et al., 2015). Angeli and Jaiswal (2016) stressed this factor explaining how allopathic healthcare services are only considered when the health conditions of the patients become very serious in developing countries. The cost of healthcare plays a vital role in the 'health-seeking' trends of patients observed in developing countries. It comes from the understanding that the majority of the developing countries like; Pakistan, India, Bangladesh, and Nepal (WHO, 2017)lack a free and quality healthcare system that would be adequate for the needs of the common population (Shaikh et al., 2017). Furthermore, it is found that one of the root cause undermining effective and efficient healthcare access (in Pakistan)is the cost of medical treatments and the risk of catastrophic healthcare expenditures. The risk that costly expenditures might push the low-income households further below the poverty line prevents the patients from attaining quality healthcare and leads to the scenario where services from unqualified traditional healers are preferred (Balarajan et al., 2011).

From the service provider's side, it is very complicated to deliver in low-income healthcare settings due to extreme affordability requirements and the infrastructural barriers which include; poor availability of transportation, electric supply, lack of government support, shortage of trained support, and lack of formal market institutions

(Balarajan et al., 2011). It is due to these reasons that the affordability of low-income groups in developing countries is difficult to achieve, where the quality of treatment cannot be compromised.

The Global economic recession which began in 2007 (Basu et al., 2012) lead to chief constraints on government budgets. As of 2014, developing countries such as Pakistan, Nigeria, India, and Algeria spent 0.7, 0.9, 1.4, and 5.2 percent of their total GDP on public healthcare expenditure respectively (WorldBank, 2018), whereas, developed states like Canada, Denmark, and United Kingdom were spending 7.4%, 9.2% and 7.6% on healthcare. These alarming figures led to the intervention by Global welfare Organizations to protect and alleviate basic health rights for people residing in developing states (WHO, 2017). Developing countries that were already struggling to provide effective healthcare to the citizens through public means were recommended by International Monetary Fund (IMF) and World Bank to increase the scope of private healthcare provision (WorldBank, 2018) as a part of loan conditions (WHO, 2018). The Sub-Saharan and South Asian states were kept in prime focus by World Health Organization (WHO, 2017) because of multiple reasons which include; poor economic conditions (Khursheed et al., 2015), political instability (WorldBank, 2017), lack of healthcare research (UNO, 2017) and inability to allot more GDP for free accessible healthcare for citizens (Akram and Khan, 2007). Such conditions paved way for the private sector to dominate all across the developing countries (Basu et al., 2012) and by 2017 it is seen that the monopoly of the private sector prevailed in countries like Pakistan, Bangladesh, Nigeria, and South Sudan (Peters et al., 2007, Basu et. al., 2012, WHO, 2017). The table below illustrates the latest conducted percentage distribution of health consultations in the public and private sector of Pakistan (2004-2005) by the Federal Bureau of Statistics:

Type of Health Facility	Urban (%)	Rural (%)	Overall (%)
Private Hospitals/Clinics	79.80	75.9	71.2
Public Hospitals/Basic Health Units	20.99	24.1	22.8

Table 2.8: Percentage of public/private healthcare distribution in Pakistan

2.14 OVERVIEW OF DEVELOPING COUNTRIES IN CONTEXT TO SDL

The application and feasibility of SDL in the healthcare sector of developing countries can be best understood from the 5 axioms described by Vargo and Lusch (2016). This section will describe the current condition of developing countries concerning the adaptability of SDL and the bottlenecks that these countries face to cocreate value amongst the different actors of the service eco-system.

Axiom1: Service is the fundamental basis of exchange

When it comes to the service structure and the significance of service delivery in developing countries, the presence of numerous challenges is observed in the healthcare sector (Angeli and Jaiswal, 2016). The most important bottleneck seen in this regard is the overall understanding of services and their significance as a fundamental basis of exchange (Shaikh, 2015). As the majority of the developing countries are based on economies that are run by agricultural and/or industrial sectors, the focus has had always been prioritized on ‘goods dominant logic’ as the first and only choice for marketing (Vargo and Lusch, 2015). Emphasis on the production of tangible outputs, adapted by the businesses and organizations, creates an environment in the economy that values goods/capital as the basis of exchange. Being transaction-oriented and measuring success in terms of production, developing economies tend to adhere to the use of operand resources (Vargo and Lusch, 2004).

All of the above applies to the healthcare sector of developing countries where focus on the volume of patients (from the doctor's end) and focus on the cost of treatment (from the patient's end) leads to an economy that disregards the significance and concept of services. With these conditions, the concept of the application of specialized skills and knowledge as the fundamental basis of exchange can be seen being non-existent, making unfavorable conditions to implement SDL in the healthcare sector.

Axiom 2: Value is cocreated by multiple actors, always including the beneficiary

The concept of SDL stresses the fact that value is created by various actors in a service eco-system, where the service beneficiary is regarded as the most significant actor (Vargo and Lusch, 2015). The importance of multiple actors in a service eco-system is previously discussed in this chapter highlighting how each actor *supplements* the other through exchanging competencies. This logic makes it crucial for service providers to firstly, understand the importance of the roles of multiple actors, and secondly to establish an environment where value is cocreated amongst those actors in a value network. Also, as these findings are majorly compiled in developed countries, where the influx of patients is equally distributed, the status of customers (patients) is naturally regarded with the potential to further favor their needs.

However, the situation observed in developing countries is somewhat contrary to the developed states, where the never-ending influx of patients is directed towards private healthcare due to the poor performance of the public healthcare institutions (Khursheed et al., 2015). This phenomenon creates a scenario where the weight of all healthcare needs falls to the private sector (Ahmed and Sheikh, 2008). Due to high demand and low supply conditions, the private healthcare clinics in developing countries are seen to attain a position where the inflow of patients is unaffected by the offered service quality (Ashill et al., 2008), patient satisfaction (Lubeck et al., 2000b) and the proposed value (Zhang et al., 2015). Under this situation, value cocreation with the beneficiary becomes less attractive to the service providers and the sole focus is targeted towards increasing the patient volume. The same trend can be observed for the other actors like; suppliers, staff, and stakeholders, who are chosen based on

competitive costs, production efficiency, and distribution, etc.

Concludingly, it can be said that the end goal of healthcare providers in developing countries, under such conditions of uninterrupted demand, is observed to disregard patients and other actors of the service ecosystem as value cocreators, making the presence of SDL negligible.

Axiom 3: All social and economic actors are resource integrators

Service Dominant logic considers all social and economic actors as resource integrators (Vargo and Lusch, 2008). The understanding of the statement: "*Resources are not; they become*" (Vargo and Lusch, 2004) follows that value cocreation transpires through assimilating actor resources in accord with their expectations and needs (Gummesson, 1994). In context to the developing countries, such ideology is often not understood or considered while designing the service delivery structure. Explaining the reason for this occurrence is rather complex and can be only understood from the 'domino effect' that makes the healthcare sector of developing countries less susceptible to SDL. To begin with, the main reason can be seen as the sense of competition that exists in the healthcare sector of developing countries, along with the urge to captivate a higher share of the market. To acquire a higher share, the healthcare providers (usually private) tend to spend less on the amenities that directly/indirectly lead to resource integration via operant resources. An example in this context can be taken from the deliberate desist of IT services that directly/indirectly help to share knowledge amongst various actors in a service eco-system. A higher focus on keeping the costs low by avoiding IT services, though, give a competitive edge to organizations in keeping the costs low, but in the long run devoid those organizations to integrate resources amongst all social and economic actors.

Concludingly, it is seen that the resources are best integrated where knowledge, skills, expertise, and feedback are shared amongst various actors. All the actors including focal, direct collaborative, indirect support, or shareholders, actively engage in the process of value creation with various forms and have the common purpose for value cocreation. Contrastingly, in the conditions where the focus is largely based on operand-centric resources and a sense of competition, the approach of SDL is seen

to be lagging (Vargo and Lusch, 2015).

Axiom 4: Value is always uniquely and phenomenologically determined by the beneficiary

An important factor to understand regarding developing countries is how value is perceived by the patients in the healthcare sector. It is a likely scenario where the health-seeking behavior of low-income groups in developing countries differs from the patients who are wealthy and/or who reside in a developed country. Angeli and Jaiswal (2016) stress upon the factor that, while proposing value to a healthcare delivery system in a developing country, the fundamental step is to ensure the patients are aware of their health needs and their capability to comprehend the health-enhancing potential of the proposed solution.

The value perception of patients in developing countries is significantly different from the patients living in developed countries. For developing countries, the value for patients is determined by the amalgamation of factors that include; cost of treatment, relationship to community, understanding of the significance of health-enhancing potential, cultural preferences, potential stigma, and gender (Angeli and Jaiswal, 2016). It is further diversified for the patients belonging to the upper class and the ones living under the poverty line in the developing states.

Value For Patients Living On/Under Poverty Line

Talking about the patients living under or on the poverty line, the first noticeable factor is the cost of treatment. It is observed that value for these patients is determined by how less the cost of treatment is as compared to the quality of services being provided by the service provider. The main reason for this preference is the financial condition of the patients and how majorly the cost of treatment impacts their finances and lifestyle. The other reasons are extensively discussed in the ‘cost of provision’ section of this chapter.

Moreover, cultural preferences play a vital role in value perception by patients in developing countries. It is observed that these patients perceive value based on how much the service providers adhere to their cultural needs. One example in this regard

is the behavior of women in most developing countries (Khursheed et al., 2015) who prefer to visit a Lady Doctor for all their healthcare needs (especially gynae related matters). Visiting a male GP for gynae is considered a stigma in the majority of the rural areas of the developing countries as it goes against the religious and/or cultural requirements in those societies. Healthcare setups that adhere to the cultural and religious needs of women in developing countries are perceived to be of more value than the hospitals/clinics that lack female GPs. In this regard, the capability or experience of the service providers is usually ignored, and adhering to the cultural and religious requirements is regarded as a priority (Khowaja, 2009).

Another factor in this regard is the understanding of health-enhancing potential. The research by Angeli and Jaiswal (2016) stresses the fact that the majority of the people living under the poverty line in developing countries possess low or no education to understand the potential of understanding and acquiring health-enhancing services. For such people, traditional healers and herbalists are the first choices for acquiring healthcare service based on the collective trend of the society or 'superficial claims' advertised by the unlicensed healers to cure any disease quickly and cheaper as compared to any licensed healthcare service provider. This factor can be linked to the trust and relationship element, which the patients in developing countries feel to be of more value when it comes to healthcare. The patients tend to perceive more value where the service providers use interpersonal skills in providing assurance and relationship building as a part of their services. The low-income patients of developing countries are observed to fall prey to herbalists and spiritual healers based on the reason that more focus is given by these healers to psychologically capture the customer's trust rather than focusing on the medicinal cure.

The above-mentioned literature findings point towards the fact that technologies or health-enhancing services may not be seen as immediately valuable by the patients and the need for **Value Discovery** is of utmost importance, where a cocreation process is necessary to identify the need of the patient and organization altogether (Angeli and Jaiswal, 2016).

Value For Patients Living Above Poverty Line

The value for patients living above the poverty line can be related to the value

perception of the patients living in developed countries (Angeli and Jaiswal, 2016). Studying various pieces of literature highlights the fact that the majority of the patients belonging to the upper or elite class perceive value according to the quality received, during or after obtaining treatment (Ahmed and Sheikh, 2008; Siddiqi et al., 2017). These patients are characterized as more educated, aware, and informed when it comes to availing of healthcare services. Value perception for such patients is based on; exchange of knowledge, higher engagement, experience, relationship building, and service customization. These patients are observed to be less responsive to the cost of treatment and more receptive to the quality of services.

Paying for the treatment means, purchase of service for better comfort and experience for the upper-class patients in developing countries. In this regard, better technology and relationship building is perceived as of more value along with the perks to customize their healthcare needs. An example of this trend can be taken from the study of Khowaja (2009) who identified the pattern of high-income patients in the developing countries to visit private healthcare clinics that offer costly treatment with more focus on quality and patient experience. These patients pay more for the services in order to achieve certain perks that may include cutting down on waiting times, comfortable seating areas, hygiene, better technology, and customer services. One more factor discussed in the study by Angeli and Jaiswal (2016) is 'adhering to the community trend', which can be seen in this class of patients who tend to visit high-end clinics based on the social influence and accepted norm of the upper social class. Hence, it can be said that the value for these patients comes from visiting clinics that are considered 'superior' and that provide enhanced patient services for the exchange of extra service fees.

As discussed earlier, relationship building is of utmost importance for this class of patients, and perceiving value is based on how much knowledge is transferred amongst the actors in the healthcare setups.

Axiom 5: Value cocreation is coordinated through actor-generated institutions and institutional arrangements

The fifth axiom of SDL signifies the importance of institutions and institutional arrangements in cocreating value. Vargo and Lusch (2016) stressed in their article that 'institutions' are the elements that enable actors to accomplish an ever-increasing

level of service exchange and value cocreation, under time and cognitive constraints. Hence, it can be understood that an amalgamation of social norms, formal codified laws, and conventions leads to forming a concept of more comprehensive and interrelated 'institutional arrangements (Vargo and Lusch, 2015). Moving forward, the presence and application of institutional arrangements (Vargo and Lusch, 2004) are quite crucial to the SDL application and status in the healthcare setup of developing countries. The studied literature has repeatedly focused on the absence of formal institutional arrangements in most of the developing countries (Anwar et al., 2012; Shaikh et al., 2017) leading to the scenario where various actors of the service eco-system fail to integrate resources amongst one another and resultingly fail to cocreate value (Vargo and Lusch, 2015).

In order to understand how developing countries are lacking in institutions and institutional arrangements, an example can be taken from the research of Angeli and Jaiswal (2016), who talks about the weak healthcare system of India lacking majorly in the institutional arrangements. It talks about how the weak (and sometimes undefined) government policies have led to the situation where formal institutions and institutional arrangements are non-existent in the country and organizations act according to the 'hit and trial' methods. This scenario when compared to the literature of Vargo and Lusch (2015) highlights the major reason why value cocreation is impossible to achieve in many developing countries. According to Scott (2008), institutions provide guidelines for taking certain actions as well as putting prohibition and constraints on certain actions. However, in the economies where the sense of institutions is weak along with frail institutional arrangements, the application of SDL becomes almost impossible (Vargo and Lusch, 2004). It is observed that developing countries lack a formal setup of institutional arrangements due to which the actors in a service ecosystem fail to integrate resources. Resultingly, it is seen that a mechanism for cognitively distant actors to connect through digital infrastructure is absent leading to limited or no exchange of knowledge, skills, and competencies (Nyende, 2018).

The themes that come out of the literature section demonstrate the significance of the concept of SDL and its applicability in the healthcare sector. Starting from the shift from GDL to SDL, this section has elaborated on how the focus has changed in the conceptual lens of marketing during the past decades. This chapter demonstrated the

understanding of SDL, portraying the timeframe of development in terms of foundational premises (FPs) and Axioms that were introduced from 2004 to 2016. Moreover, the researcher has presented the dynamics (Value cocreation and Contextual) that act as a tool in identifying the presence of SDL in an organization. Secondary research from multiple sources has helped the author to identify how healthcare has moved from being a 'social profit' institution to a 'service business' entity. Based on the findings of various academic researchers, this section has elaborated on a separate market segment (B2P) to which patients belong as compared to the B2C market for conventional business customers.

This section has also highlighted the increasing trend of studies being conducted to explore the applicability of SDL in healthcare. It is found that there is not enough empirical evidence to support the application of SDL in developing countries due to multiple factors that range from cultural differences to financial differences between the patients of developed and developing countries. Most of the already conducted research is noticed to focus on the developed countries with regard to SDL and its application in the healthcare sector. Lastly, it is found that value is subjective, and in-depth exploration is required to identify the role of SDL in developing countries to fill in the theoretical gap which exists in the academic literature.

CHAPTER 3 - RESEARCH METHODOLOGY

INTRODUCTION

This chapter describes the research methodology of the study, focusing on the crucial aspects of the research agenda, research philosophy, case study organization, data collection, and data analysis. The rationale for choosing the case study approach and the chosen philosophy is extensively discussed to lay strong groundwork for the findings section.

3.1 RESEARCH AGENDA

3.1.1 PURPOSE

The purpose of this research is to investigate how SDL can be applied within the healthcare empirical context i.e. A B2P service exchange relationship. The researcher has repeatedly highlighted the fact that to this date, only a few studies have been undertaken that could present empirical evidence on the applicability and credibility of SDL in healthcare settings. Furthermore, SDL's applicability in the healthcare setups of developing countries is hardly touched upon by the scientific community, which leaves a gap for the researcher to develop a fully operable framework that might be applied by the general practitioners seeking to understand and implement value cocreation relationships with the service actors. Doing so requires a practical approach, that could observe and assess the service exchange transactions (between the service actors) and through which it could be realized if value cocreation can be contributed or inhibited. To acquire empirical findings, it is necessary to observe the service exchange dynamics at a micro level i.e., between the service provider and service beneficiary (dyad). This overall scenario indicates a research agenda for the development of a conceptual framework for realizing how the service exchange unfolds in practice and for assessing the dynamics of SDL within relationships. This

framework is developed from empirical data and acquired from the exploration of the case studies.

3.1.2 AIM AND OBJECTIVES

As aforementioned, the research aim is to understand how Service Dominant Logic might be applied in the healthcare empirical context of Pakistan and capture any lessons that might be useful for theory development. Achieving the research aim will require the researcher to meet three research objectives:

1. To apply and adapt a framework based on the interpretations from the axioms and Fundamental Premises of SDL theory – which would facilitate the evaluation of SDL by determining its presence within the private healthcare organizations of Pakistan.
2. To evaluate mutual value creation in different socio-economic societies of Pakistan by assessing the presence of different service relations within a private healthcare setup.
3. To assess the application of SDL presence framework of healthcare in Pakistan, within the context of empirical evidence and SDL theory.

3.2 RESEARCH PHILOSOPHY

3.2.1 PHILOSOPHICAL POSITION

The use of beliefs and abstract ideas which inform our research is termed philosophy (Creswell, 2012). All research projects are based on philosophical assumptions (Myers, 2013), and understanding these assumptions is crucial for all researchers (Smith et al., 2002). They are typically the ‘first idea’ in the development of a study and thus relate to the overall process of the research (Creswell, 2012). It is, however,

significant to understand the importance of philosophical assumptions which underline every research being conducted. Furthermore, different researchers embrace diverse realities and evidence of these multiple realities includes presenting different perspectives. For example, Morgan and Smircich (1980) discussed the subjective and objective debate within the social sciences, etc.

Interpretive researchers have based their assumption that reality can only be understood through social construction (which includes consciousness, language instruments, and shared meanings). This assumption stresses that reality is a social construction (Myers, 2013) that cannot be understood independently of the actors who make that reality. In terms of epistemology, interpretive researchers study phenomena within their social setting. For instance, an organizational study would be conducted by this approach by an in-depth examination of the organization/s. That is how the researchers would aim to construct interpretations of practices and meanings.

Keeping the above-mentioned philosophical assumptions in focus, the researcher has tried to evaluate which position would best serve the scope of this study. The concluding factors are based on the understanding that the term '*value'* carries immense significance pertaining to this topic. "Value is believed to be cocreated by multiple actors, including the beneficiary" (Vargo and Lusch, 2015). This statement in the light of scientific knowledge can be best understood by interpretive research in which current knowledge and belief are being described, as opposed to the traditional view of marketing management, where value was perceived to be created for the beneficiary by the focus of 4 P's of the organization namely; product, price, place & promotion (Kotler and Keller, 2006). As the basic definition of interpretive research encircles social construction and shared meanings, and the research question is based on the nature of knowledge that goes in line with interpretive research, the author of the research has opted to follow this position for the proposed research.

Before setting this stance, it is important to look at the rationale of this decision which could only be understood by the core understanding of *institutional arrangements*. According to Scott (2001), institutions are human beliefs, devised rules, and norms which either ensure or restrict action and allow social life to be meaningful and predictable. It is also significant to mention here the difference between institutions and organizations to analyze this concept. Institutions do not mean organizations and

could be regarded as functionally aligned but conceptually distinct (Scott, 2008). North (1990) distinguished both as; institutions being ‘rules of the game’ and organizations being the ‘player’ (or teams). The idea to be extracted from both terms is the ‘social construction’ of rules and norms that interpret the action and not in any regard to be ‘absolute’ or positive. This would further aid in answering the research question to if the social construction of ‘cocreation of value’ leads to a better output considering SDL, as opposed to the 4 Ps of marketing mix discussed prior in this study.

Although empirical knowledge is based on observable facts, yet these facts can act fallible under new research or scrutiny. In simpler words, a statement is regarded as an observable fact by passing all tests of objectivity. However, it can be challenged by advances in knowledge and technology that can put it under innovative forms of assessment (Chalmers, 1999). This Ph.D. research is based on the ideology where the notion of SDL is found to be observable in the studied literature and practical settings. However, this exploration will also tend to make further improvements, refinements, and expansions, that would make it salient to the understanding of inductive research. As evident from the knowledge gap, the key issues warrant the absence of empirical evidence, which will be acquired by exploring SDL in the explored settings and will be determined if they can be generalized to the others (Hardy and Bryman, 2009).

Although this research entails a strong exploratory element in terms of studying SDL in the context of healthcare, other philosophical considerations of this study are also taken based on adapting to a conceptual framework that has been used in another study to determine the presence of SDL in a B2B relationship. The use of conceptual framework in this study is therefore aimed to provide a ‘logical structure of connected concepts that help provide a picture or visual display of how ideas in a study relate to one another’ (Grant and Osanloo, 2014: 17). Although seeming ‘unnatural’ to include in qualitative research, the use of conceptual frameworks in doctoral studies is seen to enjoy a growing emphasis across a range of disciplines in recent years (Berman, 2013). In this particular doctoral study, the researcher has been able to explore the presence of SDL in healthcare by including an already tested theory in a different market (B2B). Henceforth, this study can be seen as a multi-faceted approach which not only explores a new horizon but also tests an already available theory based on the guidelines from the literature review and adapted conceptual framework. To sum

up, this research will comprise of studying two case studies, for an in-depth and credible understanding of value cocreation in the healthcare sector of the developing countries.

3.2.2 JUSTIFICATION OF CASE STUDY APPROACH

Qualitative methods act as the best choice to study a particular subject in-depth (Bryman, 2008; Myers, 2013). These methods are found to be ideal for social, cultural, and political aspects of organizations (Myers, 2013). Although qualitative methods restrict research in generalizing from a sampling logic, these approaches are found to favor explorations generalizing to a theory (Yin, 1994). The author of this research aims to investigate the presence of SDL in the healthcare system of Pakistan, therefore studying more than one cases from Pakistan's healthcare market appears to be a reasonable choice. The reason behind this rationale is the generalization based on a theory which could be investigated by studying two different healthcare clinics and comparing to the already published theory on SDL. The case study approach, being one of the major elements of qualitative methods, can be understood as a strategy that focuses on understanding the dynamics of a single setting (Eisenhardt, 1989) or more than one setting as a comparative study (Yin, 1984). It is also described as an empirical inquiry that studies existing phenomena within its real-life scenario (Yin, 1984). This strategy can be understood properly from the below-mentioned definition:

"An empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used." (Yin, 1984: 04).

As evident from the above-mentioned definitions, this approach can be based on 'single' and/or 'multiple cases' for analysis, and the examination of cases can also vary on several levels depending on the requirements of the conducted research (Eisenhardt, 1989). Case studies are found to be one the most widely used methods of inquiry in qualitative research, mainly because of their flexibility and potentially rich descriptive power (Wilson and Vlosky, 1997). They act as a perfect medium for testing

theories and validating theoretical developments in a pragmatic and empirical environment. Due to the presence of such characteristics, the case study approach is found to fit well with the aim of this research i.e., to analyze value creation in different organizational settings and validate advances in an empirical environment. Choosing this method is based majorly because researchers tend to study existing literature to develop potential theories and use case studies to test their theories in the practical world. Based on the mentioned physiognomies, the researcher has found the case study approach to be the most relevant strategy for conducting exploration in the given scope of this research. This reasoning is backed by a deeper understanding of the functionality of this approach and its usefulness in collecting data. The ability of case studies to provide researchers with an in-depth analysis of the phenomenon is the main reason why the researcher believes the case study approach should be used in this piece of research.

In terms of collecting data, case studies are found to incorporate single or multiple cases. Therefore, it becomes necessary to justify how many case studies are required to conduct an exploration properly. Several researchers, in this regard, are found to present their views on how many case studies are necessary to perform credible research (Borum, 1989; Eisenhardt, 1989; Gersick, 1988). Arguments range from incorporating a minimum of 4 case studies (Eisenhardt, 1989) to involving merely a single case (Yin, 1994), which could be sufficient to generalize from while contributing significantly to scientific development (Stake, 1995). Flyvbjerg (2006), on the other hand, is seen to present its argument that it is a big misunderstanding in the scientific community to not accept a single case study research. Henceforth, it is understood that even one comprehensive case study can be enough to justify the findings in an exploration. The author, however, believes that exploring healthcare organizational settings from a developing country requires multiple case studies to compare the findings between one another. This decision is backed by the study of Darke *et al* (1998), who consider that to have an appropriate amount of cases and unit of analysis, a scope within the design and scoping of case studies is crucial (Darke et al., 1998). Therefore, multiple case studies in the author's research consist of 2 individual cases (healthcare clinics) which are presented as separate sections.

This design is used to allow extensive in-depth exploration of the cases and add more depth to the research at hand (Flyvbjerg, 2006). Moving forward, data collection

methods are usually observed to include combined methods of interviews, observations, and surveys. This acts as an advantage for using the case study method along with giving the leverage to the researcher for using mixed research methods of both qualitative and quantitative data. Horizontal structuring of case studies allows making comparisons between two or more different settings, which is adopted for this research due to the relevance.

Before advancing to the next sections that discuss the chosen healthcare clinics in detail, it is necessary to highlight the selection criterion that was considered before finalizing the cases for this study. As getting access to healthcare clinics in Pakistan during the pandemic (covid-19) was a difficult task in itself, the author approached his social circle which led to getting in touch with three CEOs of different healthcare clinics. The initial selection criteria, as mentioned in the earlier part of this chapter, was to come up with two healthcare clinics serving different socio-economic societies in Pakistan i.e., elite and middle-class. The author selected Clinic-A and Clinic-B, out of the three options, based on evident difference between the two in terms of the markets they served. This was related to the geographical location of both clinics (based in rich or middle-class societies) and was confirmed by the CEOs of both healthcare clinics before the author finalized the cases. The author also made sure that the total staff of both healthcare clinics did not exceed 50 people as that would have led to in detail service exchange mapping, which would not be possible to achieve given the timeframe of this research. The details of both healthcare clinics is presented in the next sections.

3.3 DATA COLLECTION

As aforementioned, all data has been obtained through qualitative open-ended interview questions, observations, and interaction with the service actors of both clinics. The rationale behind this choice of research instruments is based on the understanding that interviews yield direct reference from the people about their views, practice, awareness, and thoughts. Similarly, the data collected through observation contains an overall image of people's engagements, actions, behaviors, and a broad diversity of interpersonal communications and organizational processes which are the main components of evident human experience (Buriro et al., 2017). Both of these

instruments are extremely crucial to this research as this study is exploratory in nature and the details on practice/es are what add credibility to this exploration. The author is aiming to acquire an in-depth understanding of individual experiences, trends, thoughts, opinions, and to dig deeper into the problem at hand. Thus, the research instruments must satisfy all of the aforementioned requirements.

The collected information is in various formats that include, words, sentences, and phrases that reflect clinic employee/patient perceptions about the key concepts such as value creation, resource involvement, knowledge transfer, service orientation, etc. To collect data from a multiple case study approach, the author explored pieces of literature (Myers, 2013) that suggested the use of the following tactic to collect credible data for research:

1. Direct interaction with individuals on a one-to-one basis (interviews)
2. Direct interaction with individuals in a group setting

Physical presence is necessary to collect unbiased data from the sources and while conducting multiple case studies, the author ensured to follow both the above-mentioned techniques (Myers, 2013; Buriro et al., 2017). Direct interaction with individuals helped in getting detailed information whereas group settings helped the researcher to reduce unbiased data (which is possible when the source is an individual). The researcher came across researchers stressing on the significance of ‘observation’, which is a credible and effective data collection measure. Denzin and Lincoln (1994) defined observation to be a systematic data collection approach where the researcher examines natural settings with the use of all his/her senses. It is further divided into participant or non-participant observation where the researcher either joins a group to observe the activities of individuals or does not take part but observe the setting, respectively (Denzin and Lincoln 1994). The researcher has included both participant and non-participant observation techniques in the clinics to collect unbiased data.

Furthermore, the approach for data processing follows the concept of making conclusions from the raw data:

For raw data collection, the researcher developed an interview template ahead of time to ensure consistency and save time (Dillard, 2017). For this purpose, the author created templates consisting of all the important questions so that no information is

missed out. These templates were separately made for the interviews of patients, employees, and stakeholders. The second most important consideration in this step was to keep all the collected data in a log with collection dates and important notes in an order to validate conclusions (Myers, 2013) in the future.

For analysis of the data, manipulation of data is the key step. Authors have suggested different practices to manipulate and analyze data, however, the research by Dillard (2017) proved beneficial for this study as it emphasizes the use of simple 'data-analysis' tools, that make the research easier and manageable (Dillard, 2017). Henceforth, the author used 'Microsoft excel' for maintaining a log and analyzing the acquired data. Moving forward, using the strategy from the research of Dillard (2017) also helped the researcher to interpret the data with certain considerations that help in improving the overall research quality. Three main considerations to interpret data as explained in the article by Dillard (2017) are as followed:

- Does the data answer author's original question?
- Does the data help author in defending against any objections?
- Are there any limitations in conclusions or any angles that have not been considered yet?

As evident from the pointers above, the researcher made sure that the flow of the research moves in a manner that ensures answering the original question i.e., the role of SDL and value creation in the developing countries. Moreover, these considerations helped the author to reduce the chances of any research bias that could have occurred due to limitations or lack of consideration of certain viewpoints. To increase credibility, the researcher conducted interviews in a one-to-one setting along with interactions in a group to ensure unbiases in the acquired responses. The research is designed in a manner that, if the interpretation of data answers all the above-mentioned considerations, the author would progress towards a productive conclusion from the analysis of the acquired data.

3.4 CASE STUDY 1 ORGANIZATION – INAM MEDICAL CENTRE

The first organization selected for this research is a private healthcare clinic based in Lahore, Pakistan. The name of the organization is changed to: 'Inam Medical Clinic' (Clinic-A), along with the names of the CEO and COO. The reason to amend these names is based on keeping the identity of the firm confidential. Clinic-A is owned by Dr. Inam and his wife Mrs. Inam. Clinic-A is a private limited company, with all the company shares belonging to Dr. Inam and his wife. This service business is limited to one clinic that is located inside a low-to-middle income society based in the city. Due to several reasons (which will be discussed further in this study), Clinic-A is a popular choice for patients when it comes to availing healthcare services.

CLINIC-A BACKGROUND AND OPERATIONAL STRUCTURE	
PATIENTS CATERED PER DAY (AVERAGE)	650
ESTABLISHED SINCE	15 YEARS
TOTAL NUMBER OF STAFF	12
SENIOR MANAGEMENT	2 (CEO AND COO)
SOCIAL CLASS THE CLINIC CATERS TO	MIDDLE-AND-LOW-INCOME CLASS
CLINIC AREA (PER SQUARE METRE)	505

TABLE 3.1: Clinic-A Background and Operational Structure

3.4.1 SERVICE RANGE

The services offered by Clinic-A to the visiting patients are illustrated in the figure below:

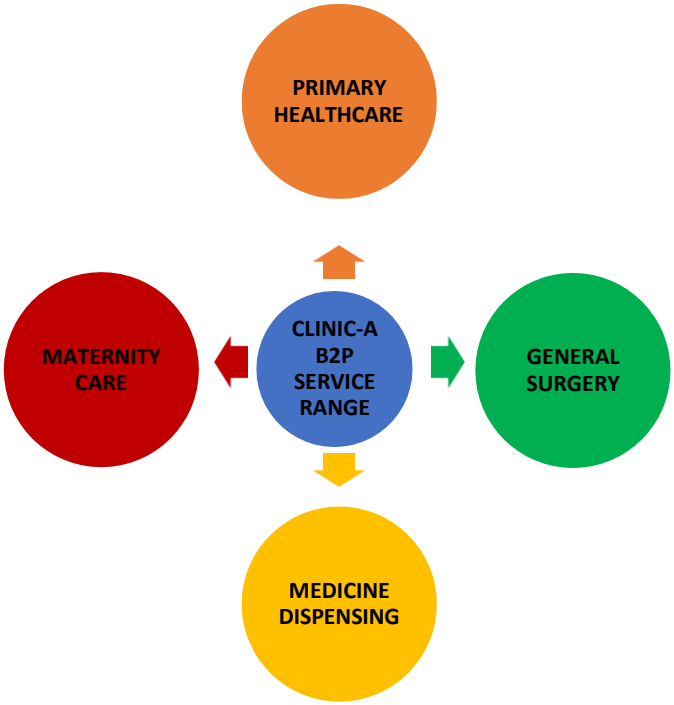


Figure 3.1: Clinic-A B2P Service Range

Clinic-A's service range can be categorized into 4 major service spheres for the visiting patients, each with its underlying service offerings. The listed domains and the offered services under each sphere are mentioned below:

1. Primary Healthcare – Disease prevention, health maintenance, counselling, diagnosis, and treatment of acute and chronic illnesses
2. General Surgery – preoperative, operative, and postoperative management of patients
3. Medicine Dispensing – In-house pharmaceutical services
4. Maternity Care – All gynae related services, examination during labor and birth, breastfeeding support

Apart from the 4 main sets of services mentioned above, Clinic-A entails sub-services to provide healthcare to the visiting patients. These sub-services include:

1. Receptionist – Greeting patients, allotting appointments, answering patient queries
2. Janitorial Services – Cleaning the clinic and medical apparatus
3. Security – Maintaining a safe environment for the visiting patients

3.4.2 DATA COLLECTION (CLINIC-A)

The data collection exercise of Clinic-A comprised of a multi-stage approach to complete the following tasks:

1. Identification and mapping of service exchange processes between the service actors
2. Analyzing patient satisfaction and service operational bottlenecks
3. Assessing the SDL presence between the service actors

Primarily, the focus of the researcher was to examine the service exchange processes that existed between Clinic-A and the visiting patients. The focal point of this exercise was to recognize if the exchange was variable or stable, and evaluating the key underlying sub-processes in the service exchange. Moreover, the researcher was interested to acquire the detailed activities, work processes, and interactions taking place between the service providers and beneficiaries. All the service exchange activities were mapped and acquiring them was based on the methods mentioned below:

1. Analysis of clinic's documentation, SOPs, work schedules, raw materials for employees, and process flow charts.
2. Observation of normal business day working activities involving the service actors and face-to-face informal discussions with the clinic's employees and patients.

As the data collection methods for this case include document analysis, observations, and in-depth interviews, it is important to justify the chosen methods and its efficacy for the case study. Starting from document analysis, it is seen that this method is effective in a manner that it provides systematic procedure for reviewing data that has been present prior to researcher's intervention (Bowen, 2009: 27). The researcher is thus aiming to view all documents that Clinic-A uses for its service exchange i.e., patient handling forms, attendance records, prescriptions, etc. Moving to observations, the most relevant benefit for opting to this data collection method is that the researcher gains the first-hand experience to what actually happens in a clinical practice (Barret and Twycross, 2018: 64). Observation in Clinic-A is opted so that unbiased data could be recorded from the clinic as the researcher will be taking notes in real time. Lastly, in-depth interviews are selected

for this case study so that the researcher can shape the conversation in real time, rather than following a pre-written schedule. This strategy is selected in order to encourage participants to share their personal experience as a narrative rather than opting to answer in a small (yes or no) answers. The researcher of this investigation interviewed same clinic staff multiple times in order to gain more trust and eliminate any research bias that might incur through the responses due to intentional or unintentional reasons. Asking questions on multiple occasions is intended to increase research accuracy.

All the data collected from Clinic-A spanned from January 2018 to March 2019 and was collected in two 2-month visits to Pakistan. The total time spent on data collection, clarification, interpretation, and compilation come up to 11 months. This timeframe includes public holidays and seasonal vacations etc.

VISIT	DURATION	FROM	TO	TIME SPENT IN CLINIC-A	PURPOSE OF THE VISIT
VISIT 1	2 MONTHS	JAN 2018	MAR 2018	5-6 DAYS PER WEEK WEEK 1-5	Analyzed clinic's documentation and interviewed Clinic-A's employees and the CEO multiple times.
				WEEK 2-8	Gathered information regarding the operational processes that defined the Clinic's service structure.
				WEEK 4-8	Interviewed patients regarding their service expectations and satisfaction levels.
VISIT 2	2 MONTHS	AUG 2018	OCT 2018	5-6 DAYS PER WEEK WEEK 1-3	Re-interviewed patients, the CEO, and employees to reduce the probability of research bias.

				WEEK 3-8	Observed and mapped the operant/operand transfer, service dynamics and variations of mutual value creation.
				WEEK 5-8	Compiled all evidence in the form of photographs, documents, and responses from service actors.

Table 3.2: CLINIC-A VISIT DETAILS

As evident from the table above, the researcher distributed tasks over multiple weeks to organize and collect data. This strategy helped categorize the presence of operant and operand resources. Looking at the daily operations facilitated this research to evaluate the nature of skills, knowledge, and information that would flow between the service actors. The focal attention of these visits was based on identifying the key elements that could correlate with the elements of a theoretical framework to help establish the presence of SDL within Clinic-A. Moreover, the researcher engaged in assembling a parallel data collection approach to assess the current existence of SDL in Clinic-A. To extract such data, it was crucial to observe the attitudes, mindsets, and behaviors of Clinic-A employees towards service delivery. Doing so helped the author to focus on the behavioral orientation of Clinic-A's employees towards the significance of services, in order to realize the then currently prevailing perception about a service-oriented approach within the organization.

For the acquisition of in-depth qualitative knowledge, the author interviewed all employees of Clinic-A and thus acquired a sample set of 14 respondents. These 14 respondents include Clinic-A employees and the senior management. The main concern for including all the service actors from Clinic-A is based on the fact that these respondents are directly or indirectly involved with elements crucial to this research.

They include relationship building, service delivery, and patient satisfaction. The table below shows the breakdown of respondents from Clinic-A.

BUSINESS AREA	RESPONDENT	No. OF RESPONDENTS
Senior Management	CEO	1
Senior Management	COO	1
Patient handling/Reception	Nurses	5
Pharmaceutical	Medicine Dispensers	4
Cleaning	Janitorial Staff	2
Security	Security Staff	1
TOTAL		**14**

Table 3.3: Clinic-A Sample Set Breakdown

Interviews conducted with the respondents comprised of open-ended questions and were held in the Urdu language (National language of Pakistan). This choice was made by the researcher to ensure that the respondents understood the questions properly and felt comfortable throughout their interviews. Each interview lasted an average of 50 minutes and the obtained responses were translated, recorded, and segmented into data chunks for supplementary analysis. One of the objectives of the researcher was to analyze if the respondents possessed behavioral inclination that was supportive of adopting an SDL-oriented approach towards service provision. Given that any inclination could be noted, that would result in warranting the effective propagation of SDL throughout Clinic-A.

The researcher had to restrict with obtaining qualitative data from the respondents due to the highly theoretical nature of discussed concepts (SDL/Value creation). This is based on the reasoning that the respondents were not fully aware of the concepts of SDL, value creation, and other terminologies, crucial to this research. Henceforth, data collection in an unsupervised, statistical base (quantitative) could have jeopardized

the credibility of this research due to the uncredible information/responses. Moreover, qualitative observations helped the researcher in acquiring a complete understanding of business processes, daily activities, and the rationale of the employees for performing the actions they were currently operating in. This approach helped the author in mapping out the complete service exchange taking place in Clinic-A. The table below demonstrates the focus of interview questions, details of interviewees, and the aspect of conducted interviews.

INTERVIEWEE (SENIOR MANAGEMENT)	TOPICS COVERED	SUPPORTED IN
CEO	Strategic Vision (3), Value creation (4), Value perception (2), Perception towards services (5), perception towards innovation (3), Marketing strategy (4), Patient needs (6), Employee Skills development (4), Training (3), Organizational Culture (5), Relationship Management (3)	Top Management Commitment in SDL, Mutual Value Creation, Resource Orientation, Service Orientation, Relationship Management, Patient's role in designing services, Knowledge Transfer
COO	Strategic Vision (3), Value creation (4), Value perception (2), Perception towards services (5), perception towards innovation (3), Marketing strategy (4), Patient needs (6), Employee Skills development (4), Training (3), Organizational Culture (5), Relationship Management (3)	Top Management Commitment in SDL, Mutual Value Creation, Resource Orientation, Service Orientation, Relationship Management, Patient's role in designing services, Knowledge Transfer

Table 3.4: Clinic-A Senior Management Interview Details

INTERVIEWEE (STAFF)	TOPICS COVERED	SUPPORTED IN
NURSES (5)	Value Perception (3), Value creation (3), perception towards services (4), perception towards patients (6), training (2), Patient needs (5), Information transfer/skill application (5)	Mutual Value Creation, Service Orientation, Relationship Management, Knowledge/Skill Transfer
DISPENSERS (4)	Value Perception (2), Value Creation (4), Perception towards services (6), training (3)	Mutual Value Creation, Service Orientation, Knowledge/Skill Transfer
JANITORS (2)	Value Perception (2), Value Creation (4), Perception towards services (6)	Mutual Value Creation, Service Orientation
SECURITY GUARD (1)	Value Perception (2), Value Creation (4), Perception towards services (6)	Mutual Value Creation, Service Orientation

Table 3.5: Clinic-A Employee Interview Details

From the understanding of the studied literature, it is crucial to understand the needs, expectations, satisfaction levels, and feedback of patients to evaluate mutual value creation properly. Patients, being the cocreators of value, were interviewed by the researcher to analyze the perceived value of Clinic-A from the service beneficiary's end. Although the clinic was visited by an average of 650 patients per day, it was difficult to obtain consent from the service beneficiaries to take part in this study. This difficulty is understood to have arisen due to multiple reasons which include, gender segregation, cultural constraints (refusal to participate in an activity led by opposite gender), limited knowledge of the explored subject, shyness to participate, and finding it difficult to trust the researcher that patient identities (associated to their responses) would be kept confidential. Although it was a challenging task, the researcher managed to interview 250 patients and record their responses with their full consent. Access to patients was entirely at the clinic's discretion and the researcher was helped by Clinic-A's staff on numerous occasions in this regard. The researcher made every possible effort to include patients with as many differences to one another as possible, for example, from different socio-economic backgrounds, different gender, age, and education levels, etc. This strategy was made to ensure a more generalized picture of

the findings and to minimize any research bias that occur due to interviewing similar patients. Henceforth, the breakdown of the sample criteria of 250 patients is demonstrated in the table below:

AGE	PATIENTS	GENDER	PATIENTS	EDUCATION LEVEL	PATIENTS
18-25	**35**			UNEDUCATED	**57**
26-35	**64**	FEMALE	**103**	PRIMARY	**63**
35-50	**83**			SECONDARY	**79**
50+	**68**	MALE	**147**	DEGREE/DIPLOMA HOLDERS	**51**

Table 3.6: Patient Sample Criteria Clinic-A

Interviews from the patients lasted for an average of 12 minutes in which the researcher asked them open-ended questions related to mutual value creation, involvement in service design, knowledge transfer, relationship management, level of satisfaction with the service provision, and their perceived value of the offered services. Interviews were conducted in a manner that supported gentle introductory questions and then moved towards specific areas of interest to this research. All interviews were taken face to face and the researcher obtained permission from some patients to audio record the responses for research purposes. The same questions were asked from all the interviewees, and the basic framework of interviews is presented below:

INTERVIEWEES	DURATION	QUESTIONS ASKED (APPROX RANGE)	TOPICS	INTERVIEWS SUPPORTED IN
250 PATIENTS FROM CLINIC-A	12 MINUTES (AVG)	30-40	Value Perception, Value Creation, understanding of service exchange processes with Clinic-A, Information transfer, perception of clinic's relationship management, Involvement in service design, satisfaction with the services offered.	Mutual Value Creation, Beneficiary's involvement in Service Design, Intensity of Knowledge Transfer, Relationship Management, Patient Satisfaction with the services offered

Table 3.7: Clinic-A - Patient Interview duration and Topics covered

The results presented in the table above were achieved by re-arranging the interview data into similar bits. All 250 patients were interviewed to share their experiences in the clinic along with any difficulty or problem they faced during their visit. Researcher made sure to acquire any feedback that the patients had to give regarding the services they received. The researcher began with recording the responses in a excel sheet from where it was possible to identify key areas (like cost effectiveness). Doing this helped the researcher to label common bits with different themes, which was next part of the process. The topics covered during the interview are hence labelled in the table next to the context in which the interviews were supported in. Section 3.7 of this research gives the details as to how the thematic analysis was achieved.

3.5 CASE STUDY 2 ORGANIZATION – SADAF SPECIALIZED CLINIC

The second organization selected for this research is a private healthcare clinic based in Islamabad, Pakistan. The actual name of this organization is changed due to confidentiality reasons and is replaced by 'Sadaf Medical Clinic' (Clinic-B). This organization is owned by Dr. Sadaf (name changed). Clinic-B also operates as a private limited company, with all the shares belonging to Dr. Sadaf. This service

business has only 1 branch (in Islamabad), which is located at a posh locality inside the capital of Pakistan. Due to several reasons (including service quality), Clinic-B is a popular choice for patients when it comes to availing of healthcare services.

CLINIC-B BACKGROUND AND OPERATIONAL STRUCTURE	
PATIENTS CATERED PER DAY (AVERAGE)	250
ESTABLISHED SINCE	3 YEARS
TOTAL NUMBER OF STAFF	34
SENIOR MANAGEMENT	2 (CEO AND COO)
SOCIAL CLASS THE CLINIC CATERS TO	GENERALLY HIGH-INCOME AND ELITE CLASS
CLINIC AREA (PER SQUARE METRE)	2145

TABLE 3.8: Clinic-B Background and Operational Structure

3.5.1 SERVICE RANGE

The services offered by Clinic-B to the visiting patients are illustrated in the figure below:

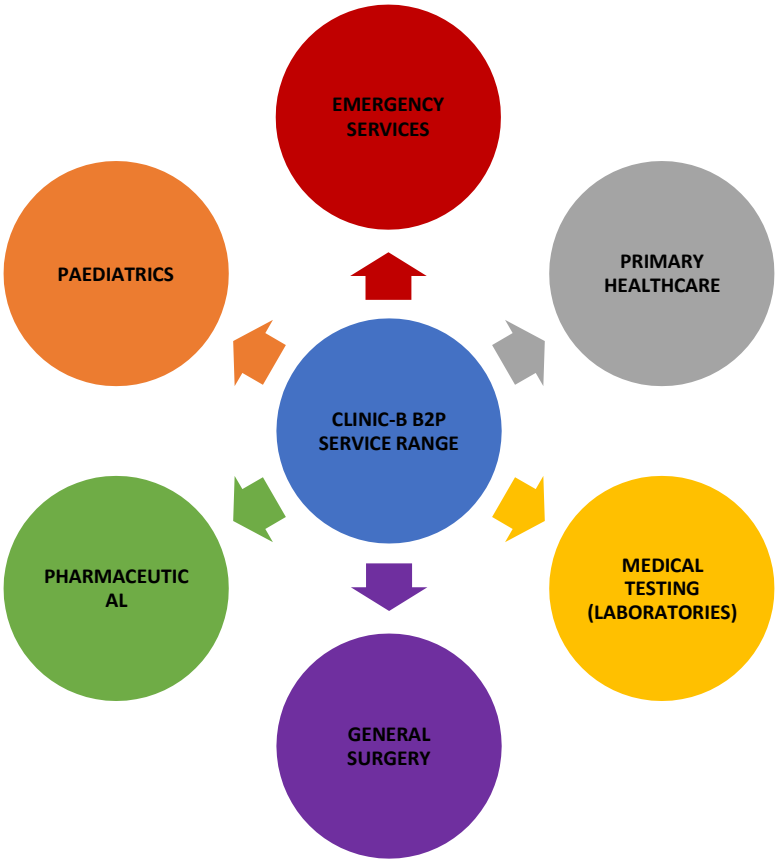


Figure 3.2: Clinic-B B2P Service Range

Clinic-B's service range can be categorized into 6 major service spheres for the associated patients, each with its own underlying offerings. Details of the services offered under each domain are mentioned below:

1. Primary Healthcare – Disease Prevention, health maintenance, counselling,diagnosis, and treatment of acute and chronic illness
2. Emergency Services – Casualty department with specialization in acute care ofpatients without prior appointment
3. General Surgery – Preoperative, operative, and postoperative management ofpatients
4. Pharmaceutical – Outsourced pharmaceutical services located within the company's premises
5. Pediatrics – Specialized medical care of infants, children, and adolescents

6. Medical Testing – Testing of clinical specimens for diagnosis, treatment, andprevention of diseases. Includes X-rays, Ultrasound, and Color Doppler testing

Along with the main set of services provided by Clinic-B, the following sub-services are mapped by the researcher that take place inside the clinic:

1. Reception – Greeting patients, allotting appointments, answering patient queries, record keeping
2. Janitorial and Housekeeping Services – Cleaning the clinic and providing housekeeping services in the private patient rooms
3. Security – Maintaining a safe environment for the staff and visiting patients
4. Nursing – Holistic care of patients encompassing psychological, physical, and developmental needs of the patients
5. Catering – Outsourced cafeteria located inside the clinic to prepare and deliver meals to the staff, patients, and visitors

3.5.2 DATA COLLECTION (CLINIC-B)

The data collection exercise of Clinic-B was conducted in the same manner as of Clinic-A. This included the multi-staged approach for identifying and mapping service exchange processes. All data from Clinic-B was collected in a 2-month visit to Pakistan, which took place from August 2019 to October 2019. The total time spent for collecting, clarifying, and compiling data comes up to 6 months, which includes public holidays and seasonal vacations, etc. Details of the visit are as followed:

VISIT	DURATION	FROM	TO	TIME SPENT IN CLINIC-B	PURPOSE OF THE VISIT
VISIT 1	2 MONTHS	AUG 2019	OCT 2019	5-6 DAYS PER WEEK WEEK 1-3	Analyzed clinic's documentation and interviewed Clinic-B's employees and stakeholders multiple times.
				WEEK 2-4	Gathered information regarding the operational processes that defined the Clinic's service structure
				WEEK 3-8	Interviewed patients regarding their service expectations and satisfaction levels.
				WEEK 4-8	Observed and mapped the operant/operand transfer, service dynamics and variations of mutual value creation.
				WEEK 6-8	Compiled all evidence in the form of photographs, documents, and responses from service actors.

TABLE 3.9: Clinic-B Visit Details

The total time spent for collecting data in Clinic-B is recorded to be 5 months shorter than that of Clinic-A. Moreover, a single visit of 2 months proved to be efficient for the researcher to acquire all the relevant information. This efficiency is attributed to the experience gained from conducting the first case study. The use of the questionnaire templates from the first clinic helped the researcher in reducing exploration time significantly in Clinic-B. Also, distributing tasks over multiple weeks helped the author to categorize the presence of operand and operant resources efficiently.

Alike Clinic-A, the researcher interviewed all the employees of Clinic-B and was able to interview a total of 36 respondents. Information acquired from the interviews helped the researcher in covering elements i.e., service delivery, value creation, patient

satisfaction, and relationship building. The table below shows the breakdown of respondents from Clinic-B.

BUSINESS AREA	RESPONDENT	No. OF RESPONDENTS
Senior Management	CEO	1
Senior Management	COO	1
Senior Management	HR/Supply Chain	2
Health Management	General Practitioners	5
Patient handling/Reception	Nurses	8
Pharmaceutical	Pharmacists	5
Cleaning/Housekeeping	Janitorial Staff	4
Paramedics	Ambulance Attendants	2
Security	Security Staff	4
Medical Testing	Laboratory Staff/Radiologists	4
TOTAL		**36**

Table 3.10: Clinic-B Sample Set Breakdown

The average time of interviews is recorded to be 1 hour and 15 minutes, after which the responses were recorded, translated, and segmented into various data chunks. The strategy applied for Clinic-B is the same as of Clinic-A, which means that detecting the behavioral inclination of all service actors (towards SDL) was made paramount in all the conducted interviews. This approach served well to map out the service exchange taking place in Clinic-B. The table below demonstrates the focus of interview questions, details of interviewees, and the aspect of conducted interviews.

INTERVIEWEE (SENIOR MANAGEMENT)	TOPICS COVERED	SUPPORTED IN
CEO	Strategic Vision (3), Value creation (4), Value perception (2), Perception towards services (5), perception towards innovation (3), Marketing strategy (4), Patient needs (6), Training (3), Organizational Culture (5)	Top Management Commitment in SDL, Mutual Value Creation, Resource Orientation, Service Orientation, Patient's role in designing services, Knowledge Transfer
COO	Strategic Vision (3), Value creation (4), Value perception (2), Perception towards services (5), perception towards innovation (3), Marketing strategy (4), Patient needs (6), Training (3), Organizational Culture (5)	Top Management Commitment in SDL, Mutual Value Creation, Resource Orientation, Service Orientation, Patient's role in designing services, Knowledge Transfer
HR/SUPPLY CHAIN MANAGERS	Value creation (4), Value perception (2), Perception towards services (5), perception towards innovation (3), Employee Skills development (4), Training (3), Organizational Culture (5), Relationship Management (3)	Top Management Commitment in SDL, Relationship Management, Mutual Value Creation, Innovation, Resource Orientation

Table 3.11: Interview criteria for Senior Management in Clinic-B

INTERVIEWEE (STAFF)	TOPICS COVERED	SUPPORTED IN
GENERAL PRACTITIONERS	Value Perception (3), Value creation (3), perception towards services (4), perception towards patients (6), training (2), Patient needs (5), Information transfer/skill application (5)	Mutual Value Creation, Service Orientation, Relationship Management, Knowledge/Skill Transfer
NURSES (8)	Value Perception (3), Value creation (3), perception towards services (4), perception towards patients (6), training (2), Patient needs (5), Information transfer/skill application (5)	Mutual Value Creation, Service Orientation, Relationship Management, Knowledge/Skill Transfer
PHARMACISTS (5)	Value Perception (2), Value Creation (4), Perception towards services (6), training (3)	Mutual Value Creation, Service Orientation, Knowledge/Skill Transfer
JANITORS (4)	Value Perception (2), Value Creation (4), Perception towards services (6)	Mutual Value Creation, Service Orientation
SECURITY GUARDS (4)	Value Perception (2), Value Creation (4), Perception towards services (6)	Mutual Value Creation, Service Orientation
RADIOLOGISTS (4)	Value Perception (3), Value creation (3), perception towards services (4), perception towards patients (6), training (2), Patient needs (5), Information transfer/skill application (5)	Mutual Value Creation, Service Orientation, Relationship Management, Knowledge/Skill Transfer
AMBULANCE ATTENDANTS (2)	Value Perception (3), Value creation (3), perception towards services (4), perception towards patients (6), training (2), Patient needs (5), Information transfer/skill application (5)	Mutual Value Creation, Service Orientation, Relationship Management, Knowledge/Skill Transfer

Table 3.12: Interview Criteria for the staff of Clinic-B

As aforementioned, it is crucial to understand the needs and expectations of all service actors to evaluate mutual value creation. The patients of Clinic-B were interviewed by the researcher to analyze the perceived value of service beneficiaries in this

organization. The researcher found an average of 500 patients visiting Clinic-B daily, which is lower than the number of patients visiting Clinic-A per day (650 patients). Obtaining consent from the patients to take part in this research proved to be easier than in Clinic-A. This is found to have resulted due to several factors which include, high educational backgrounds of patients (understanding the significance of research), supportive management of clinic (helping to introduce the researcher to the patients), and patients' interest to improve the service delivery of Clinic-B. To make the exploration credible and authentic, the author chose 250 interviews for the research that were obtained from different types of patients. The overall sample is based on the responses gathered from patients that are different in terms of age, gender, educational backgrounds, and socioeconomic backgrounds, etc. The breakdown of the patient sample is demonstrated in the table below:

AGE	PATIENTS	GENDER	PATIENTS	EDUCATION LEVEL	PATIENTS
18-25	**21**			UNEDUCATED	**4**
26-35	**58**	FEMALE	**132**	PRIMARY	**36**
35-50	**66**			SECONDARY	**89**
50+	**105**	MALE	**118**	DEGREE/DIPLOMA HOLDERS	**121**

Table 3.13: Patient Sample Criteria Clinic-A

Interviews from the patients in Clinic-B lasted for an average of 20 minutes in which the researcher asked them open-ended questions related to mutual value creation, involvement in service design, knowledge transfer, relationship management, level of satisfaction with the service provision, and their perceived value of the offered services. As evident from the table above, the patient sample shows many differences from the sample obtained from Clinic-A. Some of these dissimilarities include the presence of a higher percentage of 50+ age group patients, more female respondents as compared to the male patients and a very low percentage of uneducated patients visiting the healthcare clinic. The obvious reason for these differences is the lifestyle choices and healthy habits of the people living in this socio-economic society.

However, a detailed rationale for these differences is deliberated in the findings chapter of this research.

The interviews in Clinic-B were conducted in a similar manner (as Clinic-A) that supported gentle introductory questions and then moved towards specific areas of interest to this research. All interviews were taken face to face and the researcher obtained permission from some patients to audio record the responses for research purposes. The same questions were asked from all the interviewees, the basic framework of interviews is presented below:

INTERVIEWEES	DURATION	QUESTIONS ASKED (APPROX RANGE)	TOPICS	INTERVIEWS SUPPORTED IN
250 PATIENTS FROM CLINIC-B	20 MINUTES (AVG)	30-40	Value Perception, Value Creation, understanding of service exchange processes with Clinic-A, Information transfer, perception of clinic's relationship management, Involvement in service design, satisfaction with the services offered.	Mutual Value Creation, Beneficiary's involvement in Service Design, Intensity of Knowledge Transfer, Relationship Management, Patient Satisfaction with the services offered

Table 3.14: Patient interview duration and Topics covered in Clinic-B

The results presented in Table 3.12 were achieved in a same manner as from the patients from Clinic-A. As for open ended questions, the data had to be collected on a excel sheet from where the responses were arranged into similar bits. The common bits were later labelled to different themes and the topics (for the table) were identified. The themes originating from the responses are mentioned in the last column of the table, which shows what context the interviews were supported in.

ASSESSING PATIENT SATISFACTION IN CLINIC-A AND CLINIC-B

To this point, the researcher aimed to collect all the data and information to map the

overall exchange process between the clinics and the associated patients. Linking this data with the elements of the theoretical framework i.e., top management commitment, service orientation, resource orientation, and mutual value creation, is the next step to determine the overall levels of satisfaction that the patients experience during various phases of the exchange processes. This data is inclusive of the complaints, feedbacks, and queries that the researcher obtained from interviewing patients in both clinics.

3.6 DATA ANALYSIS

Moving forward, much attention has been given to analyzing data to ensure meaningful findings. For this purpose, a 5-stage data analysis technique has been incorporated in this study, which is adapted from the research Shulz (2012). As the name suggests, this technique has 5 stages which are mentioned below:

Stage 1: Obtaining themes from literature

Stage 2: Re-arranging interview data into similar bits

Stage 3: Labelling common bits with different themes

Stage 4: Exploring the relationship between each identified theme and sub-themes

Stage 5: Building a narrative about the ideas generated from the theme analysis

Below is the explanation of how the researcher incorporated this technique into this exploration and the themes that were extracted from the conducted case studies.

STAGE 1: OBTAINING THEMES FROM LITERATURE

The first stage includes analysis and observation of the themes that are derived from the literature. The application of this stage has already been carried out in the latter part of the literature section where the researcher incorporated the SDL theoretical

framework and the model representing the B2P market. Furthermore, the most prominent and related themes that are extracted from the literature analysis include the contextual dynamics of top management commitment, service orientation, and resource orientation as the key determinants of SDL presence. Additionally, evaluation of mutual creation dynamics revealed themes that highlighted the elements such as relationship orientation, knowledge transfer, and patient involvement in the service design process. For data analysis, the researcher kept this consideration in focus and made a strong effort to brief every respondent regarding the model elements and how they function in an SDL in the healthcare approach. An example in this regard is seen in the interview with the stakeholders of healthcare clinics who were asked to comment on the patient participation in designing clinic services. The responses received were used to determine if the top management considered patient involvement as necessary (demonstrating operant-centric mindedness) or preferred lesser involvement (demonstrating operand-centric mindedness).

STAGE 2: RE-ARRANGING INTERVIEW DATA INTO SIMILAR BITS

Moving on to the next stage required the researcher to review all responses that were acquired from conducting interviews in Clinic-A and Clinic-B. The aim of progressing into this stage was based on compiling similar or recurring elements into a single bit. This stage is very important in sorting out the raw data and collecting similar bits so that the data becomes more understandable/interpretable. Based on Shulz's (2012) study, the researcher was able to identify key areas from where different bits of data could be identified. Those areas are as followed:

1. Understanding of the term value and value creation
2. Significance of identifying the patient needs and exploiting them into value
3. Cost-effectiveness and profitability
4. Current service delivery and the potential to make advances
5. Expanding service delivery to the existing patients
6. Adherence to cultural norms and ethics
7. Ability to enhance/alter the services in response to patient demands
8. Building long-lasting relationships with the patients (existing and new patients)
9. Skills development for clinical staff to improve patient relations

10. Skills of staff to understand and convert patient expectations into service offerings
11. Managing value for existing and new patients
12. Growth and will to expand the service structure for associated patients
13. Focus on the internal capabilities of healthcare clinics
14. Development of services on an individualistic or collective approach

Above mentioned bits are examples of similar data that in turn portrays a dyadic perspective (from the service provider and beneficiary). The repetition of these data bits from the responses signifies that patient satisfaction in healthcare clinics is greatly affected by the elements mentioned above.

STAGE 3: LABELLING COMMON BITS WITH DIFFERENT THEMES

After the identification of common bits, the researcher progressed towards labelling the bits under different themes. During the second stage of data analysis, the author observed 14 repetitive bits which were narrowed down into common themes based on the similarities amongst them. Henceforth, the author ended up with 4 different themes that entail a combination of three, four, four, and three bits in one theme respectively. The rationale behind the development of these bits is related to the SDL presence framework in a manner that the themes could coincide with the corresponding levels of the framework. Labelling of the themes, obtained from data analysis, are mentioned below:

A. Operand or Operant centric resources (Bits 9, 10, and 13)
B. The trend of top management commitment (Bits 3, 5, 6, and 12)
C. Mutual value creation aspects (Bits 1, 2, 8, 11)
D. Status of service orientation (Bits 4, 7, and 14)

STAGE 4: EXPLORING THE RELATIONSHIP BETWEEN EACH IDENTIFIED THEME AND SUB-THEMES

As aforementioned, the 4 identified themes are associated with different aspects of the SDL framework. The first theme, operand, or operant resources is an integral part

of the SDL presence framework that identifies the contextual dynamics, and to what extent they can be perceived in a healthcare organization. Operant-centric organizations show more adherence towards the employee's skill set, adaptability for learning, and high patient orientation. Alternatively, operand-centric organizations demonstrate low patient orientation, strong process automation with standardized staff skills. Similarly, the trend of top management commitment falls under a theme where it is identified if the presence of commitment from the decision-makers is high or low in an organization (in terms of SDL presence). Status of service orientation is another theme that is developed through data analysis and falls under the category of contextual dynamics present in the healthcare SDL framework model. The aspects of high knowledge transfer, innovation, and high patient engagement (individualization) denote a strong presence of mutual value creation dynamics/aspects and can be located in the top section of the diamond SDL framework model. Alternatively, low mutual value creation aspects fall in the lower half of the SDL model and portray weaker transfer of knowledge, innovation, and patient engagement.

Stage 4 data analysis has pinpointed a notion in which various combinations can exist, in addition to the ones mentioned above. Observing SDL presence in Clinic-A and Clinic-B has highlighted that the views of the patients and employees are dispersed and not aligned to SDL theory in the complete essence. For example, some patients pointed to service orientation as highly reductive yet were satisfied with the value they mutually created with the clinic. These 'outliers' suggest the presence of value to be subjective in some cases and give an interesting insight into where SDL and underlying processes of mutual value creation exist in a continuum. Such findings allow the researcher to explore aspects that have not yet been covered by SDL theory and allow the author to observe the best case and worst-case perspectives to analyze the findings.

STAGE 5: BUILDING A NARRATIVE ABOUT THE IDEAS GENERATED FROM THE THEME ANALYSIS

The last step of data analysis involves exploring the developed ideas and equating them based on the interpretations acquired by different themes. Another opportunity

for the researcher is to validate the emerging narrative with the interview of a key informant that unveils the true picture of healthcare in developing countries.

CONCLUSION

This chapter unveiled the chosen methodology of this thesis i.e. A qualitative horizontal and multiple case study approach. The researcher emphasized the B2P context used, along with the details of healthcare clinics, service structures, organizational structure, unit of analysis, and overview of the B2P relationship using open-ended qualitative interviews. This chapter also discusses the patient and employee samples, from whom the data has been collected in a face-to-face interview strategy. These interviews were conducted in a single and group setting to reduce the chances of research bias. All the data is translated from Urdu to English by the researcher followed by a 5 Stage Data analysis approach taken from Shulz (2012). Findings from the data analysis are represented in the next chapter.

CHAPTER 4 – CLINIC-A FINDINGS: SDL PRESENCE AND MUTUAL VALUE CREATION

4.1 BACKGROUND – CLINIC A

For the first case study, the author chose ‘Inam Medical Centre’ (Clinic-A) which is located in the heart of Lahore city. The reason for selecting this clinic as a case study depends on the factors which include geographic location, ease of access, and most importantly the number of patients that this clinic caters to per day. As per the investigation, it was established that the clinic was being visited by an average of 650 patients on daily basis.

Clinic-A was established 15 years ago by Dr. Inam and his wife who are both MBBS (Bachelor of Medicine-Bachelor of Surgery) general practitioners and provide their services 7 days a week. This clinic was set up from the doctor's resources which is a quite common practice amongst private practitioners in developing countries (WHO, 2017). For the first 10 years, this clinic was providing primary healthcare services to the visiting patients after which the practitioners decided to incorporate the general surgery unit into their private clinic. Since then, Clinic-A is providing primary healthcare, medical dispensing, general surgery, and maternity care to all the visiting patients. As defined by EMRO (2021), the 'private medical clinics in Pakistan' mainly provide services to walk-in, emergency, and pre-registered patients, whereas Clinic-A only caters to the first 2 groups of patients. As of now, there is no registration system through which the patients could pre-register their appointment with the GP.

The total number of staff working in this clinic includes 12 people who comprise of 5 male and female nurses, 4 medicine dispensers, 2 janitorial staff, and 1 security guard. The clinic runs 2 shifts every day (morning and evening) and the staff is rotated between these 2 shifts to help the operations run effectively. The organizational chart below shows the hierarchy of Clinic-A.

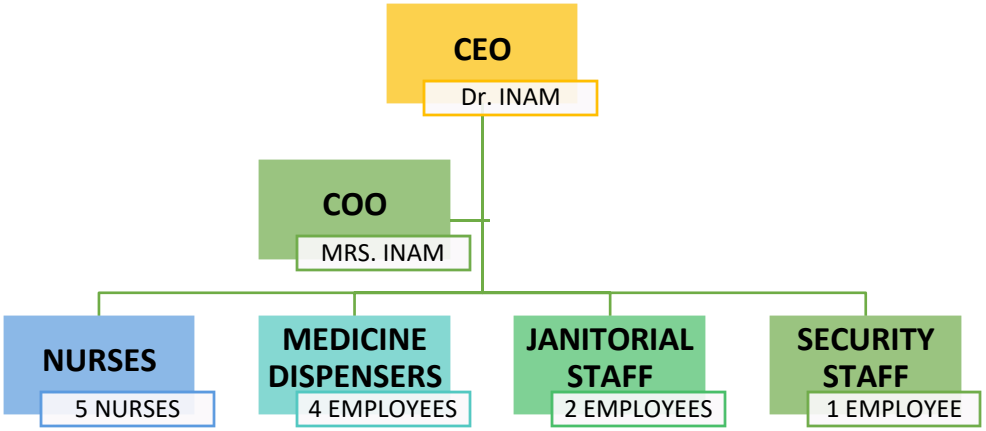


Figure 4.1: Organizational Chart of Clinic-A

The majority of patients visiting the clinic belong to a middle-class income group (as per the location of this clinic), although in general, patients from every walk do visit this clinic because of its fame in all the neighboring areas.

This clinic operates in a two-story building covering an area of 505 square meters. The ground floor is designed to accommodate primary care, secondary care, and day-to-day visiting patients. The first floor of this clinic is designed for conducting minor surgeries. Figures 4.2 and 4.3 illustrate the Map of this clinic which is not 'fit to scale' and presented to understand the space allocation and operational capacity of Clinic-A. The figures are as followed:

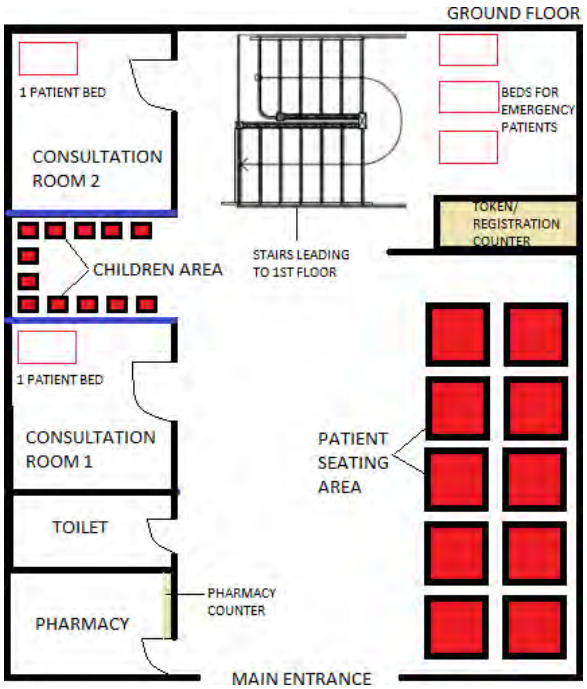


Figure 4.2: Ground Floor Plan of Clinic-A

Figure 4.2 describes the ground floor plan of Clinic-A. A small medicine dispensary/pharmacy is located next to the main entrance of the clinic. Two medical dispensers are allocated in morning and evening shifts to attend to the patients. A small counter is present from where the patients collect their medicines and receipts for their purchases. Right next to the pharmacy is a toilet that is under the use of visiting patients, staff, and both general practitioners. The first consultation room (Dr. Inam's office) is situated right next to the toilet. This is an adequate size room which comprises of a desk and chair for the general practitioner, a clinical bed for patient examination, and a seating arrangement for 3-4 persons. A small seating area is reserved for children in between the 2 consultation rooms. This area contains toys, small-sized seats, and books for the children who are accompanied by parents or guardians in the medical clinic. Right next to the children's area is the second consultation room in which Mrs. Inam provides treatment to the incoming patients. It has a similar setup to the 1st consultation room and with the same amount of clinical furniture. There is a stairway right next to the 2nd consultation room which goes up to the first floor, which as aforementioned, is designated for surgery patients.

On the right-hand side of the stairways are 3 beds which are allocated for emergency patients. The waiting area stretches from the front of the counter to the main entrance

of the clinic. This is comprised of 25 cushion chairs where the patients wait for their turn until being called for a check-up by the practitioner.

An illustration of the first-floor plan is provided in figure 4.3 followed by the detail.

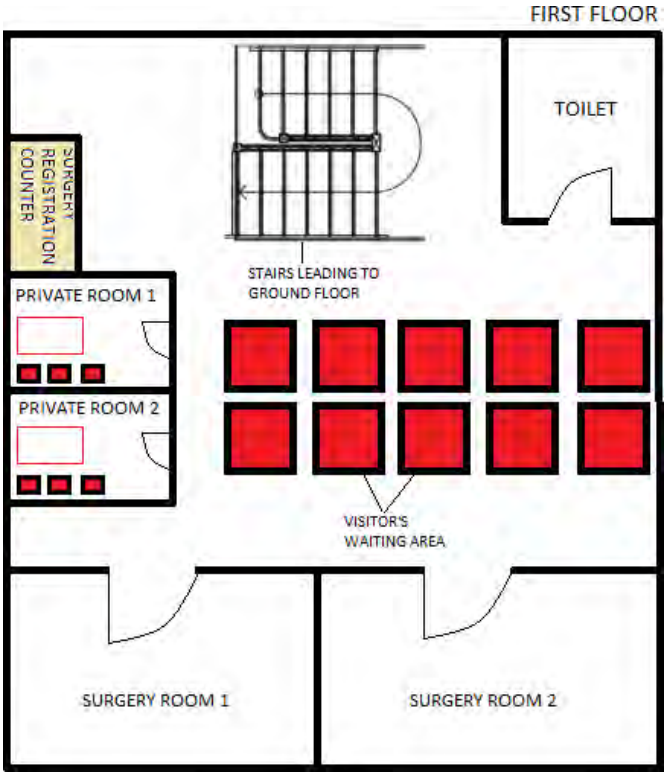


Figure 4.3: First Floor Plan of Clinic-A

The first floor of Clinic-A is solely designated for surgery patients. According to the floor plan exhibited in Figure 4.3, the toilet is situated right next to the stairways. Towards the left-hand side of the stairways is a small registration counter where all the patients who visit Clinic-A for general surgery or maternity care report. Two private rooms are situated right next to the registration counter and are allocated to the post-surgery patients who are advised to stay in the clinic until the physician provides them with a discharge slip.

There is a total of two surgery rooms on the 1st floor of Clinic-A, one is allocated for maternity care and childbirth whereas the second is being used for general surgeries. In between the stairways and surgery units, there is a seating arrangement to cater to about 15 people. This place is usually occupied by visitors who are accompanied by the surgery patients.

4.2 SDL PRESENCE – CLINIC A
4.2.1 CLINIC A – VALUE COCREATION DYNAMICS
4.2.1.1CLINIC A – SERVICE DESIGN

To understand the significance of patient's involvement in the service design of a clinical setup, the researcher will refer to the literature by Vargo and Lusch (2019) which states that; To mutually create value, organizations involve customers in the service design to deliver their services effectively (Vargo and Lusch, 2019). As the value is always uniquely and phenomenologically determined by the beneficiary (Vargo and Lusch, 2015), the two statements by Vargo and Lusch display that, for mutual cocreation of value to occur, patients have to be a big part of service design. Lubeck et al (2000b) claim innovation in service delivery to impact the patient's behavior, leading towards the cocreation of value (McColl-Kennedy et al., 2012). Hence a presence of high innovation and high patient involvement in the service design of Clinic-A would signify the clinic to be creating high mutual value creation and subsequently, low innovation and low patient involvement in service design would mean vice versa.

The observations and interviews conducted by the researcher point towards the low involvement by patients in the service design of Clinic-A, which will be detailed in the latter part of this chapter. To understand the findings of service design and patient involvement and innovation in Clinic-A, the services provided must be categorized into 7 different elements. The step-by-step detail of the service design with the element of 'presence or absence' of patient's involvement will construct a clear picture of the services of the studied clinic and will shed light on the depth of research that contributed to the demonstrated findings. The details of the provided service are as followed:

A. GP Services
B. Medicine Dispensing Services
C. Nursing Services
D. Receptionist Services
E. Surgical Services
F. Janitorial Services
G. Security Services

A. GP SERVICES

While looking at the GP services, the evidence suggests 'negligible' or 'no' patient involvement in the service design of Clinic-A. Also, no indication of service innovation could be observed after conducting numerous interviews with the staff and patients associated with the clinic. The reason for this situation can be understood from the fact that the management of Clinic-A is observed to be more inclined towards standardization of the clinical processes while avoiding customization in a majority of the services offered. The negligence of Clinic-A towards patient's involvement was observed at many places throughout the exploration and some patients were observed to be frustrated with the fact that they were not involved in the service design procedure.

To understand the reason for no patient involvement in the service design, the researcher conducted interviews with both the GPs working in the clinic. The following service structure was explained to the author by Dr. Inam and Mrs. Inam during the conducted interviews:

As demonstrated in the organizational chart of Clinic-A, 2 GPs (Mr. and Mrs. Inam) provide their services in the clinic. Both practicing doctors are accredited with MBBS degrees and provide their services 7 days a week. The practice hours designed for the GP services stretch from 11 am to 3 pm and then from 5 pm to 10 pm on daily basis. To cater to both (male and female) patients, the presence of 1 male and 1 female doctor is made compulsory. The main duty of both doctors is to provide consultation to the visiting patients during the practice hours and provide urgent care in case there are patients of emergent condition. The service design is fairly simple and made specifically for the suitability of serving GPs.

Since the standard operating hours are designed only to facilitate the working GPs, who take a lunch break from 3 pm to 5 pm, the clinic remains closed during that period on daily basis. Furthermore, there is no substitute GPs hired for Clinic-A, and for the scenario where one or both of them take sick-off or are unable to come for practice due to other reasons, the patients have to bear more waiting time and difficulty. As evident from the service structure explained above, no innovation could be recorded due to the use of operand-centric resources. Also, the high extent of service standardization was seen to be the reason for hindering any possibility of patient

involvement in the service design of Clinic-A. Evidence comes from the conducted interviews where the CEO reported 'cost efficiency' to be the reason for not employing additional GPs. The patients, however, were reported to be of the view that one or more GP in Clinic-A would be beneficial for them as they have to wait for longer durations when one of the GP is absent or busy with emergency patient/s. An interview of a patient in this regard explains the current situation of Clinic-A:

"I am highly disappointed with how the clinic devised its service delivery system. Based on how busy this clinic gets, the management should hire at least 2 more GPs who could substitute them when they are catering to the emergency patients or when they take a leave… I would have changed my family doctor in a blink of an eye if there was a better alternative in this area".

Another patient is reported to have said that:

"Waiting time in this clinic is the only thing that disappoints me every time I visit. It would be nice if there were more GPs to examine the incoming patients".

As the researcher was unable to record the patient's involvement and innovation in the service design, it can be understood that the presence of SDL in the service design along with mutual value creation is quite low.

B. MEDICINE DISPENSING SERVICES

After analyzing the pieces of literature by (Gull. B, 2008), (Anwar et al., 2012), and (Khowaja, 2009) the author observed that Clinic-A has a similar service design to a majority of small medical clinics operating in Pakistan. As previously mentioned in the literature review regarding the practices of local clinics in Pakistan, the most common practice found in small clinics is to dispense 'generic' or 'local' medication to patients due to the gift and reward culture between GPs and pharmaceutical companies. Due to following the same practice, Clinic-A exhibits no innovation, whatsoever, in the service design of medicine dispensing. The major reason to deliberately 'avoid' innovation in this criteria was also observed to be arising from the 'gifts' and 'financial benefits' from the local pharmaceutical companies for promoting their medications. As discussed earlier, the pharmaceutical companies send their representatives to the medical clinics with sample medication, gift vouchers and offer other 'financial perks',

given that the doctors promote their company's products (Mustafa et al., 2018). The researcher came across 'pharmaceutical company representatives' multiple times during conducting the case study on Clinic-A. It was observed that the visiting representatives were being given priority over the waiting patients even at busy times. Also, the medicine dispensers of Clinic-A were observed to be selling medicines to the patients in 'un-branded' and transparent polythene sachets to profit from the free medicine samples received from the pharmaceutical companies. Not only this practice is illegal but also immoral as all the samples are labelled with 'not-for-sale' notice and only provided to the doctors for promotional purposes.

As far as patient involvement in the service design is concerned, the majority of the Clinic-A patients were observed to be unaware of the unethical practices and gift cultures of pharmaceutical industries in Pakistan. The interviewed patients were seen to be satisfied with the scenario where they were able to purchase medicines from within the clinic, right after they consulted with the GP. Their lack of knowledge regarding the 'quality' of medication they were receiving, was observed to be one of the reasons why 'patient's input' regarding the involvement in the clinic's service design is seen to be quite low. As for the clinic's effort to involve the patients, the CEO was observed to be happy with the current service design because of the perks the clinic's management was enjoying from the pharmaceutical companies. One of the interviews conducted from a patient sheds light on the knowledge of patients regarding unethical practices of pharmaceutical companies in Pakistan:

"I am not aware of any pharmaceutical practice that could jeopardize the treatment I receive from this clinic. As for me, I have complete faith in my doctor that he would provide me with the best treatment".

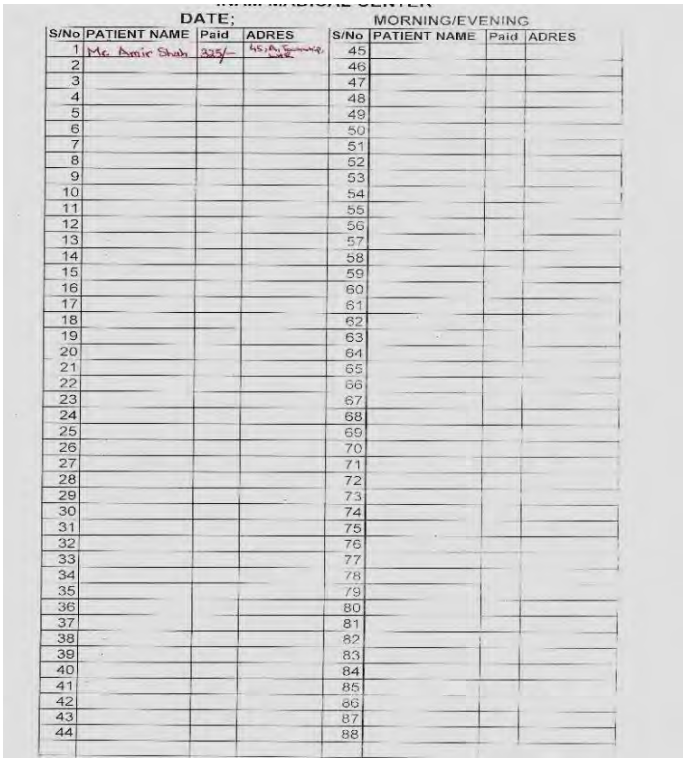
The response from the above-cited patient was almost similar to the majority of patients who were interviewed regarding the unethical practices of pharmaceutical industries. An example of the same interview question from another patient is as followed:

"The main concern for me is to have a good element of trust with my doctor, which I have, I do not think that the GP would allow any unethical dispensing of medicines".

The researcher observed lack of education to be the reason for the blind trust that the patients had towards the GPs. This finding will be further discussed in the 'Data Analysis' chapter along with the impact on mutual value creation.

To understand the service delivery mechanism of medicine dispensing in Clinic-A, the researcher conducted various interviews with the staff and management of the clinic. According to the data acquired, it was observed that 2 medicine dispensers are assigned to work in the morning shift and the other two in the evening. Further investigation revealed the following set of duties assigned to the medicine dispensers:

- The first duty of medicine dispensers in the morning shift is to check the medicine inventory. This includes arranging the medicines to the proper place/rack i.e. stacking the medicines in front whose expiry date is closer and assembling the ones on the back which have a later expiration date. Moreover, the dispensers must note the type and amount of the medicines that need to be ordered to keep the inventory up to date.
- The medical dispensers are required to maintain a register for all the medicines dispensed to patients on the daily basis. This register is to keep the record of the patient's name, payment amount, and home address of the patient. This is done on pre-printed sheets of paper which are handed over to the GP at the end of the evening shift. A photo of the sheet being used in Clinic-A is shown in figure 4.4.
- One other task of pharmacists is to check the total amount of payments received in a day and deposit it with the GP at the end of the evening shift.
- Dr. Inam is responsible for the ordering of the medicines stock so the dispensers have to give the detail of the required inventory at the end of the evening shift so that they can be ordered the early morning of the next day.



DATE; MORNING/EVENING

S/No	PATIENT NAME	Paid	ADRES	S/No	PATIENT NAME	Paid	ADRES
1	Mr. Amir Shah	325/-	[illegible]	45			
2				46			
3				47			
4				48			
5				49			
6				50			
7				51			
8				52			
9				53			
10				54			
11				55			
12				56			
13				57			
14				58			
15				59			
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30				74			
31				75			
32				76			
33				77			
34				78			
35				79			
36				80			
37				81			
38				82			
39				83			
40				84			
41				85			
42				86			
43				87			
44				88			

Figure 4.4: Medicine Dispensing Record Sheet of Clinic-A

After observing SDL presence in the service design of medicine dispensing services in Clinic-A, it has become evident that the service design is based solely on the principles of cost-efficiency rather than patient experience. The researcher, however, did not manage to observe mutual value creation in the service design of medicine dispensing services, under the current recorded situation in Clinic-A.

C. NURSING SERVICES

The evidence collected from the case study suggests 'no' patient involvement in the service design of nursing services. Also, among all the services examined, the service delivery of nurses was found to be the weakest, with many complaints recorded regarding the behavior of nurses with the visiting patients. The fact that many patients felt dissatisfied with the services of nurses indicates a 'negligible' presence of cocreation of value and indicates SDL presence to be at the lower end of the framework. Furthermore, the researcher was unable to observe 'innovation' in the service design after conducting interviews with the GPs, staff, and the patients

associated with Clinic-A. An interview conducted with a patient of Clinic-A revealed this information about the service delivery by nurses:

“I do not appreciate the way nurses in this clinic behave with the patients. It seems like they are taking out some sort of grudge on us. This sort of behavior is unacceptable!”

A key finding regarding nursing services is that the service design is solely constructed by the CEO, with priority based on the standardization of all day-to-day activities performed by the clinic's nurses. Upon interview with the CEO, the researcher was informed that there was no patient involvement in the service design and for the best interest of this clinic, it was essential to continue proposing a standardized set of services with as little customization as possible. Upon further inquiry, the CEO elaborated that the individual tailoring of nursing services on a technical level could help in improving the service delivery, but that change would require a significant amount of cost inputs, for which the management was not prepared for. The researcher found the CEO of Clinic-A to be reluctant in bearing the cost of value creation and resultingly was focused on the use of operand resources to maintain the costs of services low. CEO is reported to have said:

“Due to financial constraints, it is not a viable option for us to start individualized services for patients”.

From all the evidence collected, the researcher found nursing services to be one of the most crucial components of Clinic-A. The missed opportunity of cocreating value from these services and the impact on Clinic-A can be understood from the fact that after GPs, nurses are the actors who can play an important role in exchanging competencies given the amount of social and professional interaction they have with the visiting patients. It can hence be deduced that the current service structure is helping merely to meet ends with almost no focus on value creation that could be regarded as 'optimum' for the clinic's patients. The current service design that the researcher observed, highlights the presence of 5 nurses that are providing their services in the medical clinic. The employed nurses comprise 3 female and 2 male nurses who provide their services in the shifts assigned to them.

A background of nursing services in Pakistan is required for a deeper understanding of the roles and duties of nurses in Clinic-A. According to the studied literature, there are 3 different units of nursing practiced in Pakistan; that is, midwifery, general nursing,

and public health nursing (Gull. B, 2008). The personnel who carry a diploma in public health nursing and midwifery are referred to as ‘Lady Health Visitors’ (Gull. B, 2008). Due to the presence of maternity care and general surgery unit in Clinic-A, the clinic has only hired female nurses who are certified as 'Lady Health Visitors' (LHVs). According to the researcher's observation and the interviews conducted from the nursing staff, the following set of duties are assigned:

Clinical Services of Nurses:

- The basic services and duties of nurses include providing first aid to emergency patients. The role also includes wound dressing and changing bandages.
- Nurses in Clinic-A are required to be adept in giving Intra-veinous (IV) and Intra-muscular (IM) injections, testing blood pressure, and testing blood sugar levels.
- When it comes to providing medicinal drips to the patients, nurses have to start with a 'test dose' to check the suitability of the medicine being injected.
- Another duty for nurses is the collection and storage of samples from the patients to send them to the laboratory for analysis. The samples include urine, blood, feaces, and sputum.
- Nurses in Clinic-A are required to report directly to GP under normal and emergency circumstances.
- Other services include 'patient-information-handling'. This service is usually applicable when a repeat prescription is required.

Surgical Services of Nurses:

- Nurses are required to assist in the surgical procedures i.e. sterilizing tools, mobilizing patients in and out of operation theatre, and contributing to all the general surgeries taking place in Clinic-A
- Both the female nurses (LHVs) are responsible for maternity care, assisting in normal or cesarean deliveries and post-surgical care.

- Nurses in Clinic-A are also trained for providing local anesthesia and are instructed to do so under the supervision of a GP.
- Further services include assisting post-surgery patients to toilets and providing medicines/medicinal drips on time.

As evident from the above-mentioned set of nursing services, it can be observed that the service design is highly standardized with a major lack of vision regarding cocreation of value. This will be further discussed in detail in the ‘mutual value creation’ section of this chapter.

D. RECEPTIONIST SERVICES

An interview with the CEO of Clinic-A was conducted to inquire about patients' involvement in the service design of receptionist services, together with the information regarding the current service delivery structure. The researcher collected evidence of reductive approaches being used in Clinic-A for service orientation along with a strong focus on the use of operand-centric resources. It was explained to the author that the nurses of Clinic-A are tasked with providing reception services along with their primary role of delivering the clinical and surgical services. A key finding in this regard is the strong emphasis of top management towards 'cost reduction' which is evident from a service design that is constructed to cut the 'operational costs' and that focuses highly on 'multi-tasking', regardless of the skillset or expertise, the employees possess. Due to the observed priority on cost reduction, the patients of Clinic-A have not been encouraged to take part in the designing process of the receptionist services. Moreover, any innovation in this regard was observed to be 'highly unlikely' as the CEO himself reported the dissatisfaction of some patients regarding the service design but, meanwhile, explained how any change would not be cost-effective for the clinic.

The nurses in Clinic-A were observed to be exhausted by providing multiple services simultaneously and they shared their concerns regarding the current service design upon responding to the interview questions. The current service structure had a negative impact on the behavior of nurses and the patients were reported to be dissatisfied with the receptionist services they obtained. The absence of nurses from

the registration desk (when called inside the GP office) was noted to be the reason for delays in registering incoming patients, resulting in long queues during peak operational hours. It was also observed on many occasions that the nurses on the reception desks were administering injections or checking blood pressure/ sugar levels of patients along with providing services as a receptionist. This practice of multiple tasks was leading to ignoring of 'hygiene practice' due to lack of time management and immense workload. One of the interviewed patients is responded to have said:

"The management of this clinic failed to involve patient involvement in the service design of reception services. The nurses are frequently called by the GPs to their offices, leaving the reception desk empty. This unnecessary waiting time is not only frustrating but also disappointing".

Another patient of Clinic-A is reported to have said:

“Half of the time, the receptionists are busy tending to the GP office or texting on their mobile phones, no wonder the waiting times are unbearably long”.

The service structure of receptionists (nurses) is as followed:

- Noting down the name and age of the patients along with the reason for their visit
- Providing the patients with a token number that determines their turn in the patient queue for medical consultation with GP
- Calling the patients upon their turn and escorting them to the GP's office
- Receptionists were observed for being called from time to time by the GP's through the intercom as it is a part of their service structure to report to the GP's office whenever being called (this is usually done to give special instructions regarding the treatment of patients)

E. SURGICAL SERVICES

As explained earlier in the introduction section, the first floor of Clinic-A has a surgical setup that comprises 2 operation theatres and 2 private rooms for the patients to recover post-surgery. Both the GP's working in Clinic-A are registered MBBS doctors and having an authentic license from Pakistan Medical and Dental Association (PMDA) allows them to perform minor surgeries in their private setup (Decker, 2019).

As the surgical unit in Clinic-A became operational only 5 years ago, it is observed to comprise of a basic setup with limited services being offered. The observed presence and lack of patient involvement in the surgical services of Clinic-A became apparent after conducting multiple interviews with the CEO of the clinic and will be discussed in this chapter.

It is to be noted that the researcher found Clinic-A to exhibit a slight form of patient involvement in the surgical services. The positive indicators of SDL presence include the decision of the CEO to incorporate a surgical setup in Clinic-A after understanding the need of the patients to be provided with a privately-run surgical setup. Also, the decision to incorporate 2 private rooms for the post-surgery patients to recover is based on the patient involvement in service design, expecting satisfactory post-surgical treatment from the clinic. These measures from the management of Clinic-A were recorded to exhibit some presence of SDL in the service design of surgical services. To further explore the extent to which the SDL presence could be recorded, the researcher conducted additional interviews with the management and patients of Clinic-A.

The additional interviews mostly revealed negative indicators of SDL presence which include the observation where all the patients were seen to be transferred from the GP performing surgery, to the GP providing consultations on the ground floor. Upon inquiry, the CEO is reported to have said that:

"When one GP is performing surgery in the clinic, the patients of that GP are automatically transferred to the other GP until the surgery is complete. We follow this practice to ensure the smooth running of operations. In case, a patient decides to receive consultation from the same GP who have seen them before, we ask them to visit the clinic in future when it is convenient for the patients".

The practice described by the CEO explains the situation where the visiting patients are left with no choice but to be treated by the other GP or to visit in the future. This practice not only increases the waiting time for consultation but also leads to frustration for the visiting patients. The evidence of such frustration can be understood from the interview of one of the female patients who was interviewed by the researcher. She is reported to have said:

“There have been more than two occasions where I was told that the lady doctor, who I came to see for consultation, is busy conducting a surgery. I was given an option by the receptionist to either come back at a later time or be seen by Dr. Inam… Personally, I find this scenario to be quite frustrating as I am more comfortable with discussing my condition with the lady doctor who is already familiar with my medical history. It is not feasible for me to come back at later times and then wait in ques again to be seen by the doctor. I expect a more reliable substitute (female doctor) in case my GP is conducting a surgery”.

The researcher received similar responses from a majority of interviewed patients and observed a lack of SDL presence in the service design of surgical services of Clinic-A in this domain. Further investigation revealed the service design of surgical services which allowed the patients to stay in the private post-surgical rooms for a maximum of one day. Under the current service design, the patients are expected to vacate the premises at the closing time of the clinic on the same day of surgery. Additional information regarding the reason for this service design was explained to the researcher by the receptionist, who stated that:

"The surgery patients are expected to leave the premises by 10:00 pm on the same day of surgery. The reason for this practice is because the clinic only caters to minor surgeries and the need to stay overnight for the patients is not recommended. The other reason is that there is no one present in the clinic after 10:00 pm to cater to the patients".

The researcher while obtaining this information conducted interviews with some of the patients who were observed to be unhappy with the management's decision to vacate the room on the same day of surgery. Also, an observation was made where patients reported poor condition of the private rooms, mostly related to hygiene and

cleanliness. A statement from one of the interviewed patients explains the current service design of Clinic-A:

"I am associated with this clinic for maternity care for the past 8 months and my experience has been good until I had my C-section surgery 2 weeks ago. I was disappointed with the lack of hygiene and cleanliness in the private post-surgical room that I paid extra money for. Also, I was told to evacuate the room by 10:00 pm on the same day even though I was in pain due to the surgical stitches I have had post-surgery. I am very disappointed with the service design of this clinic and raised my concerns with the doctor about it."

As evident from the discussed interviews, the researcher observed missed opportunities from the management of Clinic-A to mutually cocreate value with the patients regarding surgical services. Although some patients showed positive responses regarding the presence of surgical set up in the clinic, the majority of them were dissatisfied with the lack of patient involvement to further improve the service according to the patient's expectation.

The researcher while obtaining all of the above-mentioned information, interviewed both GPs to obtain the current service design of surgical services, which is as followed:

- Out of the two doctors working in Clinic-A, one GP performs the surgery while the other continues with normal consultations.
- The surgical setup is made to cater to small-scale surgeries including child delivery, stitches and removal of appendixes, and other general surgeries.
- The maximum number of surgeries per day is limited to 2 due to the unavailability of a substitute GP.
- Nurses and janitorial staff are responsible for cleaning and are required to follow the procedure set by the CEO
- The patients are only allowed to stay one day in the private rooms due to the unavailability of staff after 10:00 pm.

F. JANITORIAL SERVICES

Cleanliness and hygiene are two very important factors when it comes to providing healthcare services (McColl-Kennedy et al., 2012). The researcher was unable to

record any measures taken by Clinic-A to involve patients in the service design by the means of personal observation. Also, the responses collected from patients suggested no innovation along with a high level of dissatisfaction regarding the current service delivery structure.

Further investigation revealed an interesting finding where the responses from the interviewed patients showed two opposite trends. One group of interviewed patients showed total dissatisfaction with the current service design, whereas the other was observed to be oblivious about the state of hygiene and cleanliness present in the clinic. The main reason was observed to be a lack of awareness and education, for the patients unaffected by the unhygienic state of the clinic. This factor will be discussed in detail in the 'Discussion' chapter of this thesis. Another finding regarding the current service design of janitorial services was observed to be arising from the lack of vision by top management. Highly standardized services along with standardized staff skills were observed to be the reason for the current situation in Clinic-A. To verify the researcher's observations, multiple interviews with the janitorial staff were conducted. One employee is reported to have said:

"The cleaning tasks are assigned to us by Dr. Inam personally. We have to follow the procedure set out by CEO and report to him if any cleaning utensils or stock is running out so that he can purchase them for us… Our usual routine is to start cleaning the entire clinic from the ground floor before moving to the surgical area. After cleaning the full clinic, we are expected to stay until closing to tidy up the clinic whenever there is a need for it".

The researcher found used cotton swabs and clinical waste on the floor on various occasions while exploring the clinic. This was observed to be the reason for standardized staff skills; as the staff is instructed to clean the clinic thoroughly in the morning, the janitorial staff pays lesser attention to cleaning due to lower adaptability to learn and respond to situations. Responses from the patients also depicted dissatisfaction towards cleanliness in the clinic. One of the patients is reported to have said:

“A child vomited near the reception desk half an hour ago, yet there is no sign of janitors to clean that area up. I have personally seen two/three people stepping on it unknowingly. I expect better cleaning services in this clinic”.

The current service design revolves around the 2 janitors hired by the CEO of Clinic-A. As per the interviews conducted, the janitors work on alternate days in the week and are assigned a full day shift.

The current service design of Clinic-A janitors is mentioned below:

- The employee has to report to the CEO in the morning shift
- The services assigned are to clean the whole of the clinic starting from the ground floor and then moving to the first floor
- The employee has to report to CEO before the stock runs out so that an order can be placed
- There are two main cleaning shifts assigned, one is in the morning and the second one at 5 pm when the clinic opens after a lunch break

G. SECURITY SERVICES

For the safety and wellbeing of visiting patients, the CEO of Clinic-A has hired 1 security guard who provides his service 7 days a week. After conducting several interviews with the staff and patients of Clinic-A, the researcher found a reasonable amount of patient involvement in the service being discussed. It came to the researcher's attention that the clinic was operating without the services of security personnel but due to some theft and robbery incidents in the locality of the clinic, the patients showed their concern due to which a security guard was hired.

Further interviews led to the findings that Clinic-A has had been solely relying on the services of one security guard and on various occasions the clinic had to operate without one, especially when the guard took a day off or was off sick. In this regard, the author found these services to be of inferior quality and to some extent unreliable. Upon interviewing the security guard, the following set of duties were obtained, which are mentioned below:

- The employee starts his shift 15 minutes before the arrival of GP/s to the clinic and is responsible to unlock the main doors and GP offices
- The guard has to be stationed at the entrance of the clinic throughout the day.
- There is one lunch break assigned to the guard which is from 3 to 5 pm

- The guard finishes his shift 15 minutes after the departure of GP/s and is responsible to lock the GP offices and main entrance of Clinic-A.

SUMMARY OF OVERALL PATIENT INVOLVEMENT IN THE SERVICE DESIGN OF CLINIC-A

As it has been previously discussed that Clinic-A works on the principles of cost reduction strategies, which hinders the ability to involve customers in the service design. The lack of feedback and complaint mechanism makes it harder for the management of the clinic to understand the needs and wants of patients. One patient, who is a full-time teacher in college, was interviewed regarding this scenario and is reported to have said:

"I strongly believe that the management of the clinic does not encourage patient's involvement in the services they provide. The system that they (clinic) follow is the only system they can perform to. The clinic has not paid any attention to the patients complaining about unavailability of air-conditioners, bigger seating area and improvement in the waiting time of patients visiting this clinic".

The researcher after conducting various interviews observed low innovation and patient involvement in the service design of this clinic. It was observed that the patients in this clinic were not provided with opportunities to aid in designing health services. However, in the studied literature, some researchers were found to highlight the methods through which many organizations were providing opportunities for customers or patients to involve them in their organization's service design (Yang et al., 2015). Some of the strategies that were mentioned include conducting surveys and creating polls etc.

The researcher after observing the situation in Clinic-A strongly believes that, for cocreation of value to occur in this clinic, it is imperative that the patients not only become central to the service design but also aid towards the production and continuous development of the clinic's services (Freire and Sangiorgy, 2010).

4.2.1.2 INTENSITY OF KNOWLEDGE TRANSFER

The study of literature review presented various arguments by the researchers explaining the significance of knowledge transfer between the healthcare providers and patients to mutually cocreate value. However, in this case study, the researcher collected data from the general practitioners, clinical staff, and patients separately to determine the extent to which the knowledge is shared/transferred between all parties. As we are focusing on the mutual cocreation of value (not only mutual value creation), it is pertinent to focus on all actors in the network rather than the 2 actor relationship i.e. doctor to patient relationship (Yang et al., 2015).

The researcher conducted interviews with Mr. and Mrs. Inam after observing 20 consultations between the doctors and patients. The questions asked in this interview were particularly based on the knowledge of transfer between both actors. The detail of interview with Dr. Inam is mentioned as followed:

"As a family doctor, my goal is to obtain as much information from the patients as possible but given the time constraints and long queues of patients, sometimes we have to cut short the diagnosis time to be more efficient with our services… As far as knowledge transfer is concerned, we do convey all the important information that we must professionally convey. A small issue arises where we have to deal with patients with low or no educational background... Most of these patients fail to describe their health conditions properly, and we too avoid details of diagnosis due to their limited understanding and rather focus more on medication and precautionary measures to cure the disease/s".

Although Dr. Inam emphasized that the details of diagnosis were only avoided in cases where patients with limited understanding were seen but on the contrary, the researcher noticed a lack of knowledge transfer between the GP and the majority of the visiting patients. It is pertinent to mention here that the researcher was allowed by the CEO to witness various consultations and the observation during those consultations led the author to determine that the detail of the diagnosis was only provided upon the inquiry by a patient, otherwise, the focus of both the GPs was towards prescribing medications and mentioning any precautionary measures if there

was a need for it. The original doctor-patient relational approach centered on human values and needs was observed to be lacking in all the observed consultations.

Moving towards the interviews of clinical staff, it was noticed that the clinic does not maintain clinical records of patients, and therefore, there is no system to keep the records of existing patients of Clinic-A. When it comes to the transfer of knowledge, the availability of the patient health records, and an organized patient's medical history is of key importance to a healthcare institution. An article published in 2016 stressed the fact that; clinical records are the aid of sharing of relevant information and multi-disciplinary team communication. Also, they help in the coordination of care and improve the availability of data risk assessment (Mathioudakis et al., 2016). The intensity of knowledge transfer becomes significantly low if the doctor has to rely on the patient's word-of-mouth for past ailments, diagnosis, and medications (Mathioudakis et al., 2016). Consequently, it reduces the ability of risk assessment and lowers the chances of prescribing the best medication. One of the interviewed described the intensity of knowledge transfer as:

"I worked at another clinic before being employed here. There used to be medical records for all the associated patients, and that used to make the transfer of knowledge much more efficient. Unfortunately, we do not have this luxury over here".

Looking at the interviews of patients regarding the transfer of knowledge and, linking this information with the intensity of SDL presence, the patients were observed to be neutral towards the brief consultations they were receiving from the doctors for their diagnosis and/or treatment. Though it was highlighted by many patients that they were finding it difficult to interact with the doctors in busy hours, and consequently it was becoming difficult for them to share key information with the doctor. As interactions are one of the biggest sources of transferring knowledge, they also provide the therapeutic models satisfactory to both the doctor and patient to achieve the co-creation of values in medicine and healthcare (Saviano et al., 2010). One of the interviewed patients is reported to have said:

"I do not mind brief consultations as long as the GP understands the symptoms of my ailment. However, it becomes very difficult to discuss the problems with my GP during the busy hours".

In this section, the researcher observed many occasions where the ability to transfer intense knowledge was either underscored or completely ignored. Hence cocreation of value can be assumed to be negligible given the low presence of SDL.

4.2.1.3 RELATIONSHIP MANAGEMENT BETWEEN SERVICE PROVIDER/BENEFICIARY

Good relationship management between the service provider and beneficiary ensures cocreation of value amongst the two actors (Vargo and Lusch, 2015). To examine the mutual value creation in Clinic-A, the researcher observed all measures the clinic was taking to build and retain a good relationship with the visiting patients. In contrast to observing the role of the clinic, the researcher also interviewed several patients to examine the patient's role in maintaining the relationship and further developing it.

As for the role of the clinic, it was found that the clinic did not invest in an official website, social networking page, or mobile phone application to interact with the patients. As aforementioned, such marketing tools help organizations to build a good relationship with the patients and the absence of these tools makes it harder for organizations to attract and retain relationships over a longer period. Moreover, an important aspect for the healthcare clinic is to make the patients aware of the value they receive in being a service beneficiary. In the case of Clinic-A, relation-building tactics like; discounts in medicines purchased from the clinic's dispensary or service of priority checkup could not be observed. Upon interviewing the clinic staff, it was observed that due to being shorthanded for managing a high influx of patients, relationship-building measures have not been given enough time and importance. Upon interviewing a nurse of Clinic-A, the researcher asked her to enlighten her input in building a relationship with the patients. She explained it as:

"Most of the time the clinic is full of patients. We, being understaffed on most occasions, can only try to be polite with our patients and provide them with the best of our conduct. I do admit that that sometimes it gets frustrating when we have to cater to a higher number of patients than we have anticipated on a particular day".

As seen from the interview, the staff was seen to lose motivation to give their best services under pressure and busy hours. At these times it becomes almost impossible for the clinic to create value with the patients or to even make them aware of the value they can have from being associated with the clinic.

One important factor that needs to be addressed here is the point of view of the service beneficiary in relationship management. As building a relationship requires input from both the actors (service provider and beneficiary), it is crucial that the beneficiary understands what the service provider expects from him/her. As aforementioned in the literature section, the service provider may need to educate the beneficiary on how to develop the relationship further. In the case of Clinic-A, it is not so easy as all these factors are interlinked with contextual and value creation dynamics. It can be further understood by the facts that; educating the beneficiary on developing a relationship requires more transfer of knowledge between the actors. Transfer of knowledge, on the other hand, requires a strong individualized relationship orientation. And to have a strong individualized relationship, the clinic would have to include patients in service designing and create an atmosphere of accommodative service orientation. A patient was interviewed regarding this scenario, their response is found to be quite useful for this study:

“I would love to have a strong relationship with this clinic as I consider Dr. Inam to be my family doctor. The problem is that there is no one to listen to my feedback or suggestions. Also, the clinic is too busy at times that you (as a patient) just want to get your medicine and go back home”.

After reviewing all the mentioned observations, the researcher concludes that the clinic is lacking in building strong relationship management with the patients and losing on mutual value creation.

4.2.2 CONTEXTUAL DYNAMICS

It was established in the literature review section that contextual dynamics focus on the behavioral elements whereas value creation dynamics on transactional ones. In

this case study, the contextual elements would relate to the top management commitment of the clinic, resource orientation, and lastly the service orientation of IMC. The contextual dynamics of Inam medical clinic are as followed:

4.2.2.1 TOP MANAGEMENT COMMITMENT

Top management commitment is one of the key behavioral elements to implement SDL throughout the organization. To understand the role of top management commitment in the first clinic, the researcher has divided this dynamic into 3 categories namely, top management towards staff, towards technology and innovation, and lastly towards relationship building. All three aspects will be discussed in this section to demonstrate an in-depth understanding of its application and effectiveness in Clinic-A. Details are as followed:

4.2.2.1 A TOP MANAGEMENT COMMITMENT TOWARDS STAFF

Several interviews from the practicing GPs and clinical staff led to the researcher's observation that the top management's commitment towards staff is relatively 'insufficient'. These observations and the analysis will be discussed in element in the 'Discussion' chapter, however, some key points will also be deliberated in this section to be able to demonstrate an in-depth reflection of the clinic.

It is observed that the hired staff of Clinic-A has not been trained on the assigned duties, instead, it is expected from the working staff to demonstrate good performance based on their past professional experience. The primary reason for this prospect is that all the staff hired in Clinic-A has prior experience of working in other clinics/hospitals. A primary reason for insufficient training can be assessed from the fact that Clinic-A has no HR/Training department, through which the staff could be skilled for their required tasks. The CEO of Clinic-A explained the reasons for not having departmentalization in the clinic in the following words:

"Having more staff and building departments in this clinic is not cost-effective at all. We charge our patients a very low amount of consultation fee and resultingly we must

operate on minimal staff to come up with a profit. Staff with prior work experience helps us to invest an almost negligible amount of money for training and that is how we are managing to run this company for past 15 years…"

The statement by Dr. Inam stresses 2 main factors. First, the clinic is managed under the principles of 'cost-reduction' strategy which does not allow any room for expenses towards staff training, and secondly that the top management is content with the results of the past 15 years, hence, the motivation for paving any way for 'innovation' or 'technological advancement' in Clinic-A could be perceived as 'negligible'.

Another aspect that the researcher noticed was the absence of the company's vision or its significance towards the working staff in Clinic-A. Upon interview, most of the staff was unaware of the company vision and the goals of the clinic. One example in this regard is an interview with a nurse of Clinic-A, who is reported to have said,

"Not quite sure, but I think the company vision is to see us deliver our best and make no mistakes at all".

We can link this aspect with the institutional theory discussed in the literature review section, specifically by Scott, where institutions are seen as the rules providing guidelines and resources for taking action/s and also to prohibit or constraint some (Scott, 2008). The researcher noticed the same trend in all the employees of Clinic-A, being unaware of the clinic's vision. It can thus be deduced that in a company where rules providing guidelines for taking some actions and avoiding some is absent, the sense of institutionalism and service ecosystem will not prevail, and hence value cocreation and service exchange will be at risk (Vargo and Lusch, 2015).

Furthermore, an interview with Dr. Inam highlighted the concept of 'one-man-show' regarding top management's role towards working staff. It was observed that the CEO was putting effort into building mutual value creation with the patients to some extent, but the shared vision was observed to be missing when it came to the other employees working in Clinic-A. In one of the interviews, the CEO is reported to have said that:

"I consider it very important to work on mutual value creation with patients and build a good relationship with them, for this purpose I keep my behavior professional and pay attention to all the needs of visiting patients… As far as the staff is concerned, mostly they are very busy with incoming patients, hence it is expected from them to perform

to the standard protocols, avoid any mistakes and rectify any mistakes, if or when they occur".

An observation regarding the top management commitment can now be related to the discussion in the literature review section of this thesis, where top management commitment and a strong focus on service excellence does not justify the obvious scenario where the whole organization would have the same mindset. One-man-show cannot yield results to cocreation of value as compared to an embedded SDL approach, into the DNA of the whole organization (Vargo and Lusch, 2019).

4.2.2.1 B TOP MANAGEMENT COMMITMENT TOWARDS TECHNOLOGY AND INNOVATION

The first observation made by the researcher after visiting Clinic-A was noticing the lack of attention paid to technology in the clinic. Some major findings in this regard are noticing the use of handwritten format when it comes to prescriptions, receipts, and all the clinical paperwork/documentation. Other evidence includes the absence of printers, computers, internet connection, and almost any technological facility for the staff or patients in Clinic-A. The researcher came across the practice where 'token number' (which is used to determine the turn of a patient in the queue for consultation) was also being written by pens/pencils by the receptionists. All these observations emphasize the top management's 'low' commitment towards advancement in technology and innovation inside Clinic-A. To verify these observations, the researcher interviewed Mrs. Inam, who is one of the stakeholders of Clinic-A and a practicing doctor at the clinic. She explained the conditions as:

"Use of technology is no doubt appealing but it also comes up with a price that I and my husband see as 'not affordable'. Bringing technological changes will not only incur costs for the equipment and its installation but also for the training of staff to operate that technology. In some cases, we might have to hire more staff or replace the current one as most employees in this clinic have minimal education or skills to perform better with new technology. For us, bringing this change would become a burden, rather than a blessing."

The researcher observed that due to the bottlenecks that Mrs. Inam mentioned in the interview, the clinic was 'acting' reluctant towards allowing technological advancement and innovation. As the factor of 'cost-reduction' is seen to be 'highly prioritized' in the mindset of top management, both the practicing GPs are reluctant to bring about a change in this clinic or invest more for innovation in Clinic-A.

Further interviews from the medicine dispensers highlighted some problems the clinic was facing due to a lack of top management commitment in technology. One of the medical dispensers reportedly said that,

"We have had some problems of supply and demand of medicines over time. Most of the time it is due to the newly hired dispensers who either forget to check the stock or fail to report to the doctor that medicine is about to finish on time… I believe that an automated stock-keeping system would help reduce human errors in this regard".

This interview highlighted some facts that the clinic staff feels the need for better technology in the clinic and faces some problems due to its unavailability. Also, clinics that have their supply chain and logistic systems tend to reduce the occurrence of stock issues (Yang et al., 2015).

4.2.2.1 C TOP MANAGEMENT COMMITMENT TOWARDS RELATION-BUILDING WITH PATIENTS

A very big responsibility that lies on the top management is to make efforts for good relationship building with clients, or 'patients' in this case. Customer retention is one of the big factors that determine the success or failure of a company. Although the researcher discussed the efforts of Dr. Inam in building good relationships with the patients, the staff was found to be lagging in this area. An important revelation is the 30% patient response that deems staff to have bad behavior with the visiting patients. Moreover, the clinic is not involved in patient engaging activities that include a reminder for appointments, maintenance of patient medical history, etc.

The majority of the interviewed patients explained their reason to re-visit this clinic solely based on the good relationship with the GP. An example from a patient's interview response is as followed:

“The only reason I would visit this clinic again is because of Dr. Inam. Otherwise, I am not too fond of the staff that works here.”

The question that arises here is that how much is the percentage of patients that the clinic loses because of the poor behavior by Clinic-A’s staff? A strict or more organized focus from the top management on relation-building can help the clinics to become more patient-focused on building a strong relationship which in turn would yield high patient retention.

4.2.2.2 RESOURCE ORIENTATION

The interviews with top management and researcher's observation show a high focus on the use of operand-centric resources in Clinic-A. The first observation in this regard is the standardized skills of staff and the strong focus on standardized operational processes. The top management of the clinic is observed to be interested in expecting standard clinical skills from staff and following a strict code of set operations. Although in a clinical setting it can be seen as a positive indicator that a strict standard protocol is applied and where a slight mishap can result in a medical disaster, on the other hand, the staff's adaptability for learning also gets compromised under such practices (Yan and Kung, 2018).

To understand the operations occurring in this clinic in-depth, an interview with a nurse was conducted which revealed the following information,

“I am expected to follow all standard procedures and perform my services in the pre-defined and standardized manner. Any deviation from the set standards can consequently jeopardize my job… Sometimes it does get frustrating in situations where our experience is telling us to do things differently, but we still have to follow what the top management has instructed us to do”.

The nurse who gave this information in confidentiality (with full consent to use in the research) reveals the same point that the author Ojasalo (2001) has made in his article about managing customer expectations in professional services; High focus on operand-centric resources sometimes hinder the adaptability to learn (Ojasalo, 2001) and consequently results in creating lower service value (Vargo and Lusch, 2004).

Furthermore, the researcher observed a medium to weak patient orientation in Clinic-A. Many pieces of literature have pointed out the fact that a good organization makes customer-oriented services a culture, norm, and corporate value. In the case of this clinic, at one place, Clinic-A is respecting the norms and values for the patients by keeping separate clinical staff (male and female) to adhere to the custom norms but at the same time, the basic needs of patients such as air-conditioned environment, comfortable seating, throughput time, etc. are being ignored. While discussing the patient dissatisfaction percentages, it has been touched upon by the researcher, that the management's ability to orient the services towards patients is low even after awareness of the dissatisfaction indicators. A high focus on operand-centric resources is leading to a scenario where value creation is being compromised on the organizational level and the basic reasons for this contribution are the 'cost-reduction' and standardized procedure mechanisms.

4.2.2.3 SERVICE ORIENTATION

To understand, if the service orientation of this clinic is accommodative or reductive, the researcher conducted various interviews of staff, doctors, and the visiting patients. The three main factors considered to comprehend the orientation were the focus of the clinic on cost and/or patient experience, the focus on relation-building and/or service standardization, and the ability to customize services. The detail of the service orientation of Clinic-A is as followed.

When it comes to focusing on patient experience or cost reduction, the clinic has a higher tendency to limit the costs that it incurs in running the organization. The belief of top management is to minimize the costs to reap profits from the services provided. If the old school of thought of 'goods-dominant logic' is taken into consideration, it

might have been a good strategy to reduce the costs but from the outcomes of 'conducted interviews' and the literature studied regarding SDL, it can be seen that the patient dissatisfaction is mounting, and consequently, the clinic is failing to cocreate value on multiple grounds. The clinic willingly or unwillingly is compromising on the quality of services provided due to the low budget it allocates for service provision. Patient experience also portrays the same outcome that the clinic is reductive in the service orientation. To further understand the cost reduction strategy of this clinic in more depth, the researcher interviewed the COO, who is reported to have said:

"To minimize the costs, we are cutting down our finances in three categories. The first one is the products and equipment present in this clinic, the second is unnecessary maintenance of the clinic, and lastly on the cost of services provided… We as an organization do not believe in fancy products or equipment, rather we spend on the basic needs and necessities. Also, we consider proper medical treatment to be more significant than spending on costly and 'non-urgent maintenances' or hiring costly staff, merely based on extra certifications or strong educational background".

From personal observation and information gathered via interviews, the researcher found out that the service orientation of this clinic is reductive in terms of a higher focus towards cost reduction than patient experience. Small examples like; usage of mercury sphygmomanometer (instead of digital sphygmomanometer), leakage of water pipes in toilets, faded paint on the clinic walls and low qualifications of clinic staff justify the reductive approach taken by the management of Clinic-A.

Moving forward, the concept of service standardization and/or the focus on care was observed by the researcher to realize the service provision of this clinic. It was detected that from service designing to service execution, the staff of Clinic-A is instructed to follow the pre-defined standard protocol. It can be established now that this 'standardization' at one place is helping the clinic to run its operations smoothly but on the other hand, it is depriving the clinical staff of adapting and enhancing services of the clinic. As it was recognized in the literature review section of this research, medical clinics are different from other consumer enterprises, in terms of the difference in the service expectations from the customers, who in this case are patients (Elg et al., 2013). The patients in medical organizations expect more personalized services like 'trust' and 'assurances' on top of normal B2C relationships (Bitner et al.,

2013). Hence, a strong focus on service standardization is becoming a hurdle between building a relationship with patients and providing quality care. On these grounds, this clinic is believed to be compromising on the mutual value creation leading to minimal chances for cocreation of value.

The last factor related to service orientation and being closely related to the focus on standardized services is the clinic's ability to customize services for the visiting patients. Clinic-A was observed to have a low ability to customize services for the patients. An example in this regard is an interview with a middle-aged disabled patient who came to see Dr. Inam at his clinic. The patient is reported to have said:

"This is my fourth year of coming to this clinic for my medical needs. As you can see, I am physically disabled since a very young age due to poliovirus and because of that, I am restricted to a wheelchair for any sort of commute. I have mentioned to the management of this clinic on multiple occasions that I find it very difficult to come here due to a lack of disabled access. It has been 4 years and still the male nurse or my 'carer' has to help me get inside the clinic and the management has done nothing to help me or people like me."

Here it can be seen that the management has a low ability to customize the services for its patients. To cocreate value in the clinic, the management has to prioritize patients' personal needs and incorporate measures that would add value to the services being offered.

In this section, the researcher learned that this clinic has a strong focus on reductive service orientation which consequently put this clinic at the lower end (vertical) of the SDL presence framework.

4.2.3 MUTUAL VALUE CREATION

Both sets of dynamics present in the SDL presence framework impact the overall mutual value creation. It has been observed that the clinic lies on the lower end of SDL presence in the SDL presence framework when analyzed through the contextual and

value creation dynamics. To verify the findings, the researcher has drawn on the conceptualized mutual value creation logic developed from the existing literature. From low top management commitment, use of operand-centric resources, and a strong focus on cost-reduction to low involvement of patients in service design, weak knowledge transfer, and standardized relationships, are all the leading factors towards a lower presence of mutual value creation. To determine the mutually created value between Clinic-A and the patients, the researcher has considered; **technical**, **financial,** and **perceptional value** based on the understanding of studied pieces of literature explaining SDL in healthcare settings. Further analysis of both case studies including the concept of 'value cocreation' will be discussed in the 'data analysis' chapter.

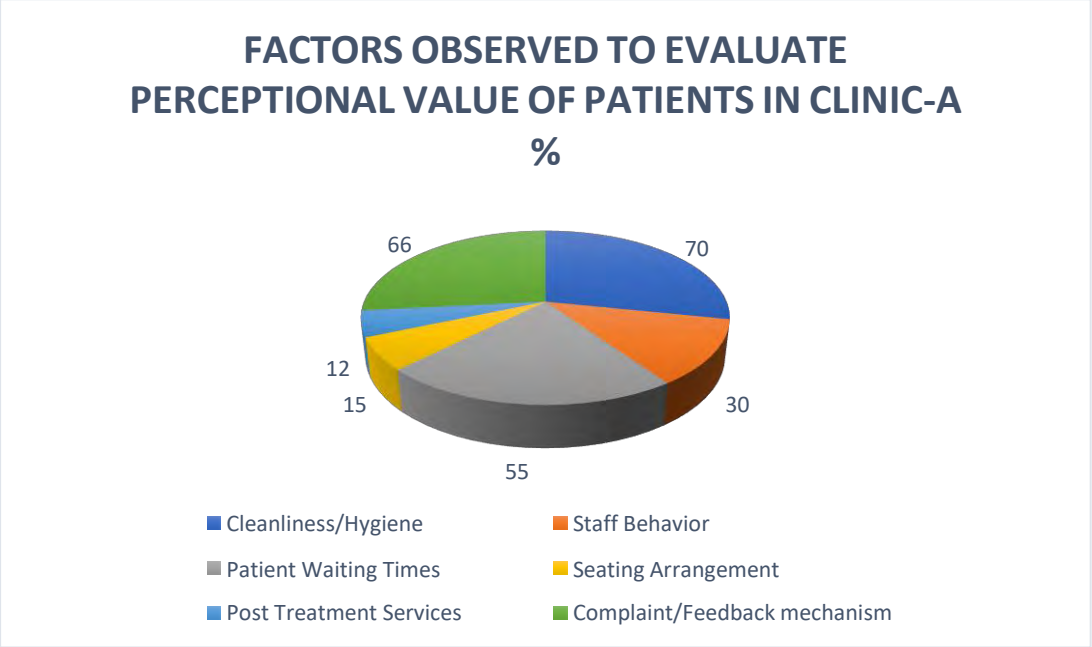


Figure 4.5: Factors Observed to Evaluate Perception Value Of Patients InClinic-A

The factors observed to evaluate the perceptional value of patients in Clinic-A include cleanliness of the clinic, behavior of medical staff, waiting time for consultation with GP, seating arrangement, post-treatment services, and complaint/feedback mechanism. Detail is as followed.

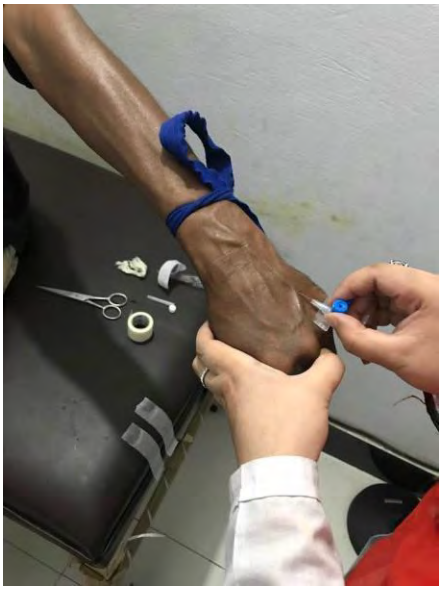
4.2.3.1 CLEANLINESS/HYGIENE

A total of 70 percent of patients showed dissatisfaction regarding the cleanliness and hygiene maintained at Clinic-A. The researcher's self-observation also highlighted the fact that the condition of the medical clinic was poor with dusty furniture and a lack of measures taken for hygiene. Disposal of used alcohol swabs is one of the examples of critical negligence that was noticed while exploring this case study. This can be understood from the information shared by the World Health Organization regarding the improper disposal of used alcohol swabs that carry the blood of patients, and which can contaminate other people upon physical contact (WHO, 2010). Another observation made by the researcher reflects the handling of surgical tools in Clinic-A. The researcher observed on many occasions that the surgical equipment was not maintained in a hygienic manner which consequently poses a great threat to patients already suffering from a weak immune system. According to WHO (2020), one of the major reasons for contamination arises due to the mishandling of surgical equipment in healthcare facilities.

Photographs A and B were taken by the researcher inside Clinic-A which represents the lack of cleanliness and hygiene measures inside the clinic.

PHOTOGRAPH A: REFLECTING THE HYGIENE CONDITIONS OF CLINIC-A (RECEPTION DESK)

Photograph A was taken by the researcher while investigating Clinic-A. The photo represents the reception desk present in the clinic. The lack of hygiene is evident from the photograph, where cotton (swab) and scissors can be seen placed on the desk without any proper measure. Also, the condition of waste bins portrays the negligence of the staff of Clinic-A to adhere to the norms of providing quality healthcare to the visiting patients.



PHOTOGRAPH B: REFLECTING LACK OF HYGIENE/ HANDLING OF MEDICAL TOOLS

Photograph B was taken by the researcher in Clinic-A. The photograph represents a nurse of Clinic-A while administering an Intravenous drip to a visiting patient. It can be observed that the surgical equipment is placed on the clinical bed. This practice is extremely unhygienic as the surface might carry a lot of germs which can cause problems to the patient being treated by the nurse.

4.2.3.2 BEHAVIOR OF STAFF

From the interviewed patients, 30% showed dissatisfaction towards the behavior of staff with the visiting patients. This is a considerably high percentage of people who have had problems in the past due to staff's behavior. Upon further inquiry by the researcher, a various number of reasons were discussed by patients regarding the

dissatisfaction of the said service; Many patients reported having problems getting registered over the counter. Further responses by patients revealed the attitude of clinical staff *working clumsily and taking too long for registration*. A patient in his interview is reported to have said:

"The nurses working at reception have ignored me on many occasions. Even today they kept the patients waiting in the queue while they were busy using their cell phones and not paying attention to our queries".

Other patients quoted issues regarding communication with the staff, according to the majority of the interviewed patients:

“The staff in this clinic is busy all the time and they do not communicate to us properly. The patients have to call them repeatedly to discuss our issues or queries with them”.

Lastly, interviewed patients showed a great amount of dissatisfaction over the clinic's nurses who were reported as acting carelessly while administering injections. One of the female patients quoted that she was injected at 5 different places on her arm before the nurse could inject her properly with an intravenous antibiotic. *Non-serious attitude*, *arrogant behavior* and *ignoring,* were the common terms used by interviewed patients while discussing the behavior of staff in overall data collection.

4.2.3.3 WAITING TIME

A total of 55% of patients showed dissatisfaction regarding the waiting time in Clinic-A. As discussed earlier, there is no facility through which incoming patients could book their consultations in advance, hence, the walk-in patients must check in with the clinic themselves after which they have to wait in a queue for their consultation with the GP. The average patient waiting time recorded by the researcher is 35-40 minutes in non-peak times. In some cases, the interviewed patients reported that they had to wait more than 1 hour before they were called for their turn. The peak time which is 5:00 pm to 9:00 pm is the one in which patients had to wait for longer times due to several patients coming in for a checkup. Patients shared their annoyance over the time management, especially in the case of parents who brought their children to see the doctor or the ones who could not leave their young children behind at home. Moreover,

the patients complained that due to emergency patients coming in often, their turns get further delayed as the GPs have to cater to them on a priority basis.

4.2.3.4 SEATING ARRANGEMENT

Seating arrangement in Clinic-A is one of the issues the patients highlighted on multiple occurrences. 15% of the interviewed patients showed concern for improper seating arrangement and lack of seats for the incoming patients. The interviewed patients who were unhappy regarding the number of seats informed the researcher that:

"Finding a place to sit becomes quite difficult especially at the peak operation times of Clinic-A".

An observation in this regard was made by the researcher in which many patients were seen standing in the corridor at peak operational time due to the unavailability of empty seats. Furthermore, a large number of interviewed patients reported feeling *suffocated* and *restricted* due to the clinic being overcrowded by patients waiting for their turn to be examined by the GP.

A male patient of Clinic-A is reported to have said:

"The male patients are the ones who find it more difficult to be seated during peak times as the seats are usually offered to females and children as a courtesy/social norm".

Another finding related to the dissatisfaction of patients regarding seating arrangement in Clinic-A was observed to be arising from the unavailability of segregated seats for patients coming with infectious diseases. The interviewed patients showed concern regarding the risk of contamination by the patients visiting due to infectious diseases. The researcher also observed this issue present in Clinic-A as all the patient seats were seen to be arranged next to one another, which was increasing the chance of person-to-person contamination.

4.2.3.5 POST-TREATMENT SERVICES

12% of the interviewed patients showed dissatisfaction regarding the post-treatment services provided in Clinic-A. The major reason for dissatisfaction was observed to be resulting from no follow-up plan provided by the clinic to the visiting patients. The responses of interviewed patients also revealed that there was no system in Clinic-A, through which their visits were being recorded in the clinic. An interviewed patient explained the reason for her dissatisfaction as:

"Absence of a follow-up plan in Clinic-A puts more responsibility on the patients to remember their next appointment and there is no service of sending a reminder to the patients for a follow-up visit".

Due to the presence of a weak service design in Clinic-A, the patients coming for a follow-up visit were observed to go through the lengthy procedure of getting re-registered and waiting in long queues before being examined by the GP. Furthermore, many patients admitted missing follow-up visits due to forgetting about the follow-up visit or to avoid lengthy waiting times before consultation with the GP. This scenario can be seen as resulting in the disease not being properly treated or even worsened in some cases.

4.2.3.6 COMPLAINT/FEEDBACK MECHANISM

One of the factors upon which the patients showed the highest amount of dissatisfaction in Clinic-A was found to be the unavailability of complaint and feedback mechanisms. A total of 66% of visiting patients complained about a lack of proper channel through which a complaint could be lodged or feedback to be provided for improving the services in Clinic-A.

In the current scenario, patients were observed reporting directly to the GP for lodging a complaint or to provide feedback. Upon interviews with the CEO and patients of Clinic-A, the current service design was found to have both positive and negative aspects associated with it.

The positive aspect of lodging a direct complaint to the CEO is the improved chance for the issue to be addressed. This higher probability can result because of the direct communication, that the patients can have with the decision-maker (CEO). Alternatively, the negative aspect is the scenarios where the patients cannot express themselves freely, especially face-to-face, in case the complaint is regarding GPs themselves. This practice removes anonymity from the whole process of the complaint/feedback mechanism, which is very important in terms of unbiased evaluation.

4.2.4 OVERALL SATISFACTION

The investigation of Clinic-A led to alarming findings where 0% of the total interviewed patients showed overall satisfaction with the clinic. This finding indicates that all the interviewed patients had encountered a problem at least once in their visits to the clinic. This outcome indicates a low level of cocreation of value with a negligible number of exchanged competencies between the actors associated with Clinic-A. Some interviewed patients (visiting the clinic for the first time) showed less likelihood to re-visit the clinic and complained about poor service delivery they received on their visit. A patient is reported to have said:

“This is the first and last time I have come to this clinic. The amount of dissatisfaction that I had here is beyond any words”.

To further understand how value is determined by all the actors associated with Clinic-A, the researcher has divided these factors into three categories, namely, **Technical value**, **Financial value,** and **Perceptional value**. The details are as followed:

4.2.4.1 TECHNICAL VALUE

Technical value for all the actors in Clinic-A relates to the efficiency and effectiveness of the services provided and/or received. From this understanding, the efficiency of

Clinic-A can be determined by the throughput times of patients consulted, the effort required to perform the processes, the capacity of processes to perform at stated performance parameters, and the utility of operant resources. While looking at the efficiency of the clinic, it has been observed that the clinic shows negative indicators towards handling the throughout times of patients, which is the result of low effort invested in the performance of the process. The performance parameters have not been set accordingly due to the low top management commitment recorded from the exploration of Clinic-A. Furthermore, the application of knowledge and skill is recorded to be minimal due to excessive focus on cost minimization. Under such a scenario, the achievement of MVC becomes almost impossible and the clinic falls into the category of low SDL presence when studied under the SDL presence framework.

Effectiveness on the other hand relates to the extent to which value proposition is attained according to the service exchange objectives set by both of the parties (service provider and beneficiary). The researcher recorded a low-value proposition from the clinic, resulting from reductive service orientation and reflected from the strong focus to standardize service delivery processes.

From the perspective of both the actors, the researcher observed a lack of interplay of the efficiency and effective dynamics of the service exchange activities. The service exchange objectives set by the patients of Clinic-A were found to be of inferior technical value owing to a high inclination towards the cost of treatment. This factor will be discussed in the 'financial value' section of this chapter.

Concludingly, it can be said that both the service provider and beneficiaries are lagging in creating MVC by ineffective and inefficient exchange of competencies through the designed services.

4.2.4.2 FINANCIAL VALUE

The financial value from the perspective of Clinic-A is based on the principles of profit maximization by the use of cost reduction strategies. Low cost of treatment ensures a greater inflow of patients, which in turn helps the clinic to maintain high sales volume. Based on the interviews from the management of Clinic-A, the researcher was able to identify the low budget targets set for operating the clinic. It was observed that the

return on investments was far greater than the actual figure of investments shared by the management of Clinic-A. As the management of Clinic-A attempts to minimize the expenses by keeping the investments and operating costs low, the shareholders can reap more profit from the company. Furthermore, no/negligible financial commitment in terms of the use of operant resources helps the clinic to generate more profits and avoid expenses that would consequently reduce the sales profits.

Alternatively, the financial value for the patients associated with Clinic-A was observed to be more inclined towards the lower costs of treatment rather than the actual perceived value. Several interviewed patients were seen to be content with the current pricing policy of Clinic-A. Due to ease of affordability, the patients were observed to re-visit the clinic and 'overcome' their dissatisfaction with the quality of services being received. This scenario leads to an interesting finding for the developing countries where the 'cost of treatment' plays a bigger role than the quality of treatment to create mutual value creation amongst the actors of SDL.

4.2.4.3 PERCEPTIONAL VALUE

Due to the dyadic relationship of service beneficiaries and providers, the perceptional value is observed to be of key significance when it comes to determining mutual value creation. The factors upon which the perceptional value of the patients can be determined include satisfaction regarding waiting times, staff behavior, post-treatment mechanism, and cleanliness inside the clinic. The findings from this case study revealed a scenario where a high percentage of patients showed dissatisfaction regarding their perceived value in Clinic-A. The elements like; trust and ease of interaction with the GP were observed to be lagging in the case of Clinic-A and the utility of these factors was seen to diminish over time.

By focusing on the perceptional value from the perspective of Clinic-A, it was observed that the management remains unaffected by the feedback on how well the patients are being treated by the service provider. The main reason for this finding can be linked to the fact where 'financial value' is found to hold more significance to the patients of Clinic-A than the actual perceived value. This scenario gives opportunity to

the management of Clinic-A to continue the operations in the same manner with a low commitment towards creating mutual value creation with the patients.

The findings on the perceptional value of Clinic-A show a trend 'untouched' in the already published literature on SDL in healthcare. It is, therefore, necessary to evaluate how much the 'cost of treatment' and cultural context of developing countries play a role in the observed findings.

CHAPTER 4 – FINDINGS SUMMARY
• This chapter began with providing the details of Clinic-A i.e., its background, number of employees and the floor plans • The researcher attempted to map service design of Clinic-A and provided details to all the services that this clinic provides to its patients • It was found that the patient involvement in the service design was very less, and the CEO designed the services as per their convenience • Elements pertaining to the transfer of knowledge are discussed and it's highlighted that the participants of conducted interviews (staff, management, and patients) unanimously agree on less knowledge transfer amongst all actors • Findings suggest that the relationship management of Clinic-A is entirely linked/managed by the CEO and the staff is found to be lacking in creating a stronger relationship with the visiting patients • The role of top management is seen to be entirely focused on cost saving and that too on times at the cost of the quality of services provided. • Reductive service orientation and high reliance on operand centric resources are the two main findings that came up from exploring this clinic • Value perception of the visiting patients is recorded that suggest a higher sensitivity towards the cost of service provided as compared to the quality of those services. • Patients are found to show concerns regarding hygiene, cleanliness, staff attitude and other issues yet are found to keep their association with the clinic

TABLE 4.1: Chapter 4 Findings (Summary)

CHAPTER 5 – CLINIC-B FINDINGS: SDL PRESENCE AND MUTUAL VALUE CREATION

5.1 BACKGROUND – CLINIC B

For the second case study, the author chose Sadaf Medical Clinic (Clinic-B) to evaluate the presence of Service Dominant Logic (SDL) and cocreation of value in the clinic. Clinic-B was established on the 4th of January 2019, with the vision to provide quality healthcare to all pediatric and adult ailments. It is a modern healthcare facility that provides a wide array of services to incoming patients. The reason for choosing this clinic as a case study comprises of various factors including the ease of access, the reputation resulting from the quality of care, geographic location, and most importantly the number of patients visiting the clinic on daily basis.

The foundation of Clinic-B was laid by Dr. Sadaf, who is the CEO of this organization and also provides her services as an MBBS General Practitioner. The clinic operates 24 hours a day and 7 days a week and is fully funded by the CEO from her financial resources. Since the clinic became operational, it has been catering to patients visiting for primary healthcare, gynae, skin-related treatment, general surgeries, and pediatrics. Clinic-B fulfills all the requirements of EMRO (2021), which means that it caters to walk-in, emergency, and pre-registered patients.

The total number of employees working in this clinic numbers up to 36 people. Dr. Sadaf is working as a CEO and providing her services as a GP in the clinic. Working below her is the Chief Operating Officer (COO), Dr. Javed, who is working as an admin and providing his services as a GP. The remaining 34 staff includes 2 employees working in the HR/Supply Chain department, 4 male doctors, 3 lady doctors, 8 male and female nurses, 5 pharmaceutical staff, 2 laboratory staff, 2 receptionists, 4 janitorial staff, 2 ambulance drivers, and 4 security guards. A detailed organizational chart is presented in Figure 5.1 which shows the hierarchy of all the people employed in this clinic.

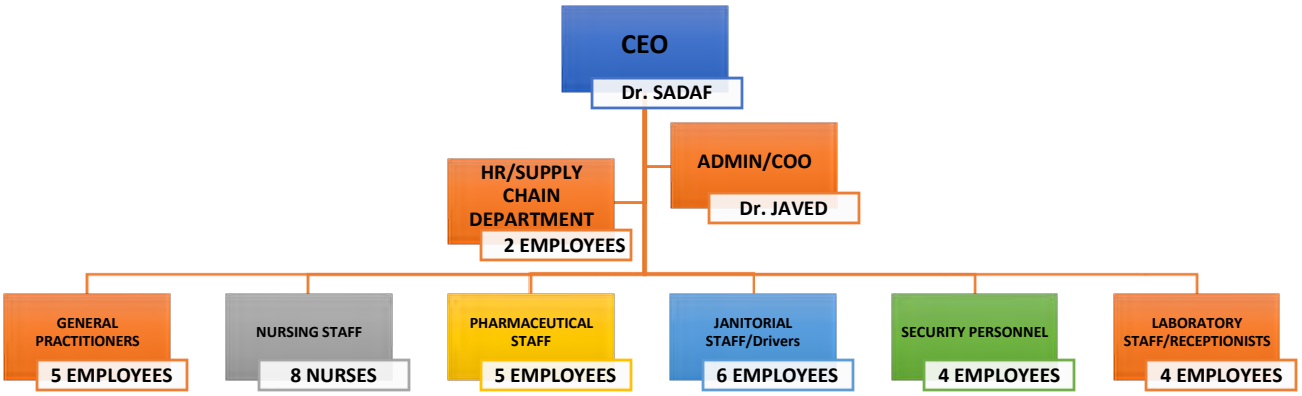


Figure 5.1: Organizational chart of Clinic-B

Clinic-B operates inside a two-story building with a covered area of 2145 square meters and is based in the suburban area of the capital city, Islamabad. The ground floor of this clinic is designed for secondary care, day-to-day visiting patients, emergency wards, laboratory, and pharmacy whereas, the first floor comprises of children ward, general ward, operation theatres, cafeteria, and office place. Figure 4.7 and 4.8 illustrates the map of this clinic which is not fit to scale and only represents the clinic plan to demonstrate how the space is allocated. Figure 5.2 and its detail is as followed:

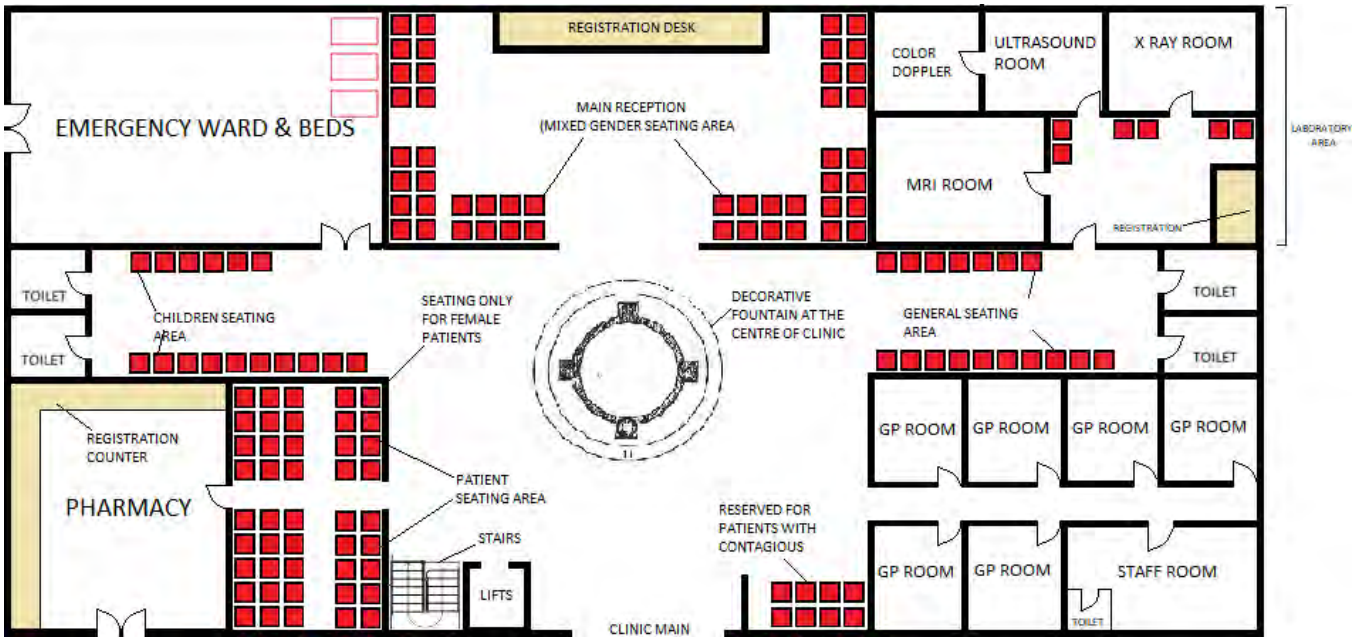


Figure 5.2: Ground Floor plan of Clinic-B (Not fit to scale)

Figure 5.2 describes the ground floor plan of Clinic-B. The main entrance is situated at the south of the building, from where the stairs and lifts lead to the first floor of the clinic. There is a total of 5 designated seating areas spread across the clinic. The first seating arrangement is right next to the stairs and reserved only for female patients and any accompanied minors. The second seating area is situated at the western side of the clinic which is reserved for the children and is built to their needs accordingly. Various sorts of entertainment tools are provided in the children's seating area so that they feel comfortable and can pass the waiting time easier. Some of the things provided in this area include toy cars, drawing books with colored pencils and crayons, rocking chairs, soft toys, and building blocks. The third seating area is located right next to the registration counter (main reception) and is used by both male and female patients. This seating area is the biggest among all other areas on this floor and can easily accommodate more than 60 patients at one time. The fourth seating area is located on the western part of the clinic and is situated right next to the laboratory space. Although this area is intended for general seating space but is usually occupied by the patients waiting for their medical test results or appointments. The fifth and last seating area is situated right next to the main entrance with a separation wall. This seating area is usually allocated to the patients who are suffering from contagious diseases and the purpose to allocate them this seating area is to minimize the chance of patient-to-patient contamination of diseases. Usually, patients suffering from influenza, dengue, hepatitis, smallpox, and measles are allocated this seating area.

A spacious pharmacy is situated in the southwestern part of Clinic-B. The main entrance of this pharmacy is accessible from outside the clinic, along with an additional entrance leading from the female patient's seating area inside the clinic. The counter for medicines spreads over two walls with huge racks of medicines displayed all over the pharmacy. A total of 3 pharmacists are always present at one time to assist the patients and dispense medicines.

Clinic-B has a designated space for emergency patients. Although this setup is not big enough to cater to life-threatening emergency cases (as compared to hospital setups) but is adequate to carry out medium-risk emergency occasions. Further details of such cases will be provided in the service design section of this case study. The emergency ward contains necessary equipment to treat incoming patients which includes a

ventilator system, oxygen supply, C.P.R machinery, electrocardiography machine, dialysis machine, and pharmacologic cardioversion machine. Furthermore, the emergency ward has about 6 beds for emergency patients and a seating space only limited to a few visitors (usually close family members or friends).

The main reception and registration area positioned in the top center of the clinic serves all the incoming patients. 2 receptionists at the counter help in the registration of patients and assist them throughout their visiting time.

Five offices for GPs are also situated on the ground floor of Clinic-B. All the practicing GPs have their own offices where they treat patients, unless or otherwise, they are assisting emergency patients in the emergency care. Although this clinic has a total of 7 GPs, two of them; Dr. Sadaf and Dr. Javed, share an executive office allocated on the first floor. All GP offices are furnished with a desk, chairs, a small cabinet, an illuminated background board to examine x-rays, a hand-sink, and a clinic bed to examine patients.

The presence of a staff room in a medical setup ensures good working conditions for all the nurses, receptionists, and laboratory staff. Hence, a staff room is built at the southeastern part of the clinic and is made spacious enough to accommodate sofas, a small dining table with chairs, necessary kitchen appliances, staff toilet, television, and lockers for the staff to put their belongings in safely. This room is only accessible by the staff and GPs who swipe their company card to enter the room.

There is a total of 5 toilets located on the ground floor of this clinic. 4 of these toilets are situated in the patient-accessible area, 2 are designated for male patients, and 2 for females. All of the clinic toilets have disabled access, along with additional space for changing the diapers of infants, in the female designated toilets. The staff toilet, on the other hand, is only accessible to nurses, doctors, laboratory staff, and receptionists and is situated in the staff room as mentioned earlier.

Lastly, there is an expansive area allocated for the clinic's laboratory which is situated at the top right corner of Clinic-B, as can be seen from the ground floor plan. The entrance to the laboratory is from inside the clinic and is divided into sub-sections which include the X-ray room, MRI room, and space for ultrasound and color doppler tests. There is a small reception situated right after the entrance from where the patients are allotted slots for medical tests or handed over their test results.

As aforementioned, the surgery setup of Clinic-B is situated on the first floor and is designed to cater specifically to the surgery patients. Figure 5.3 illustrates the detailed plan of this floor:

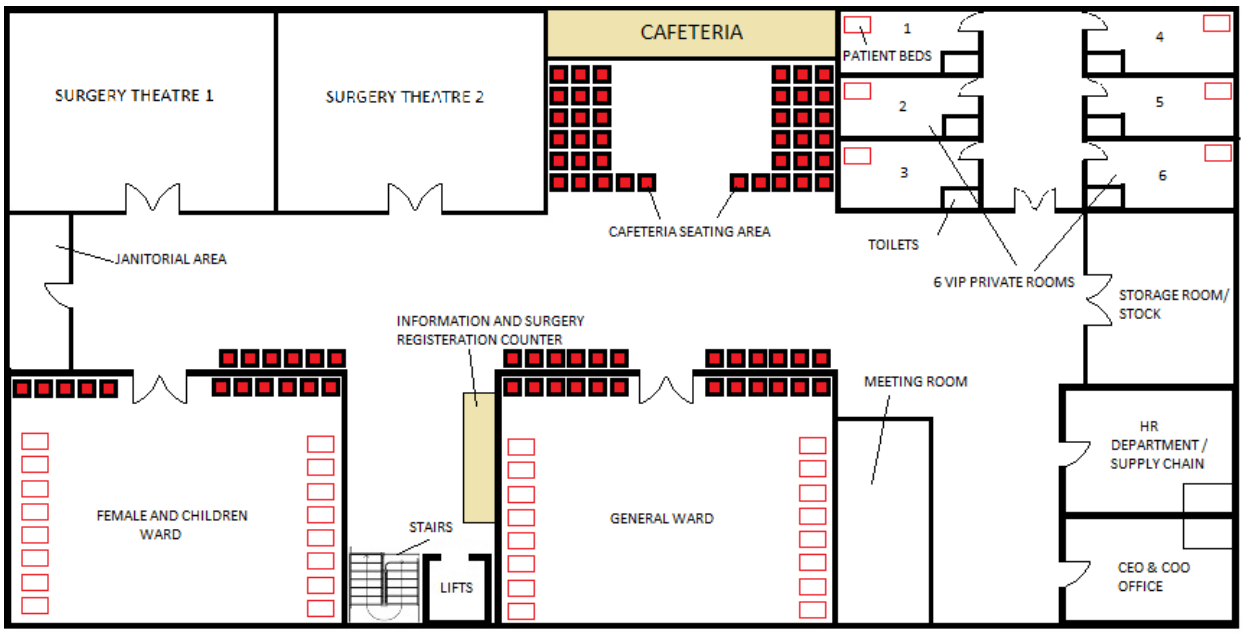


Figure 5.3: First Floor plan of Clinic-B (Not fit to scale)

Figure 5.3 representing the first floor of Clinic-B shows how much convenience is prioritized for the visiting patients by the clinic's management. As seen from the figure, the stairs and lifts lead directly in front of reception and the information counter. A little farther from there is a big corridor that leads towards other departments of the clinic.

As this clinic takes pride in specialized pediatric care, a separate ward is allocated for children and female patients on the southwestern part of this floor. This ward contains a total of 8 beds for children and 8 beds for female patients. Also, there is an optimum seating area present to accommodate the visitors during visiting hours. Other furniture and appliances present in the ward include small cabinets beside all clinic beds, air-conditioners, televisions, medicinal drip stands, pulse, and heartbeat monitoring systems, a water dispensing unit, and a small workstation for an attendant/nurse.

There is a general ward situated in the lower middle section of this floor. This ward has a total of 16 beds and has almost everything similar to the aforementioned

children's ward. This ward usually caters to the male patients admitted to this clinic and is supervised by a male nurse/attendant at all times.

As seen from the first-floor plan, the Janitorial room is situated next to the children's ward and is equipped with floor cleaning supplies, daily use cleaning items, and lockers for the janitorial staff.

There are 2 surgery rooms on the first floor, which are constructed to an adequate size, to perform general surgeries and both rooms are equipped with state-of-the-art machinery to deliver the best possible services to the patients. The surgery rooms are adjacent to one another and run-on electricity from the clinic's power generator for uninterrupted power supply.

There is a big cafeteria present on the first floor of Clinic-B with a seating capacity for over 50 people at a time and is spread throughout the front of the cafeteria reception. The cafeteria ensures timely preparation and delivery of food to the admitted patients along with serving the visitors with light snacks or main course meals.

On the top right corner of the clinic's first floor are the 6 VIP private rooms which have a separate entrance and corridor. All the private rooms are equipped with comfortable beds, air-conditioners, television, toilets, two-seater sofas and side tables with lamps, and a small dining table for patients that can be adjusted to patients' height on the beds. There is an intercom bell to ask for assistance near the bed and the rooms have maximum insulation for soundproofing.

Right across the private rooms is the storage room of the clinic. This place is used to stock, medical supplies, bedsheets, stationery, office equipment, and daily use items. This place is usually managed by the janitorial staff working in Clinic-B.

There are two offices built in the southeastern part of the clinic on the first floor. The first office is used by the HR and supply chain department. 2 employees are hired to manage both departments and their office is stocked with necessary daily use office items. The furniture and equipment in this office include workstations with office chairs, computers, file cabinets, lockers, table lamps, air-conditioners, sofas, and printers/scanners. The second office is in the use of the CEO and COO of the clinic. Dr. Sadaf and Dr. Javed spend their off-practice time in this office for all the official work. This office contains almost the same furniture and equipment as the other one.

Lastly, there is a meeting room across the offices. This place is used once or twice a week for staff meetings, discussion of agendas, and future planning. It is constructed in a shape of a hall with a big seating capacity, multimedia projector and screens, and a conference table with chairs.

5.2 SDL PRESENCE - CLINIC B

5.2.1 CLINIC B – VALUE COCREATION DYNAMICS

5.2.1.1 CLINIC B – SERVICE DESIGN

The way a process of delivering a service is designed, presented and executed greatly influences the outcomes from service and how value is created from it (Vargo and Lusch, 2004). Exploring the second case study has revealed several factors taken into consideration by the management of Clinic-B for designing their service delivery. Some key observations in this regard include the management's role in trying to incorporate innovation in the service design of this clinic and the implementation of various strategies to achieve mutual value creation with the visiting patients. The exploration began with collecting data from the CEO of Clinic-B who was observed to be highly interested in the outcomes and deeper understanding of this research, she also shared her thoughts regarding how this clinic has involved the patients in the various aspects of service design.

In the first interview with the CEO of Clinic-B, the following key points regarding the execution of service delivery processes, innovation, and patient involvement in service design were discussed:

"*The clinic that you see today looks completely different to how it was 5 months ago. We have made several changes in our service delivery and all those changes have been pointed out to us by the patients who visit us. Our waiting rooms, wards, doctors' offices, and even the entrance of the clinic have pretty much to do with the patients who gave us their valuable opinions and feedback on how we could improve our service structure. In my humble opinion, innovation is not difficult to achieve in your business if you know where to find it, and that would be our customers...*"

The main points taken from the interview regarding service design are as followed:

Waiting Rooms: Clinic-B presently has waiting areas capacity of more than 500 patients at a time. During the initial phases of this clinic, there was only 1 waiting area on the ground floor with a maximum seating capacity of 100 patients. After patients' involvement in the service design, this clinic gradually increased the seating capacity and spread it strategically on the ground and the first floor. Furthermore, central air conditioning was installed all over the clinic to ensure patient satisfaction and comfort during their visit. Another change was the segregation in the seating area which was made at the request of female patients who felt more comfortable in the female-only area (the cultural norm in Pakistan). Also, the clinic has a segregated seating area for patients who suffer from contagious diseases such as influenza, measles, etc. Installation of television in the waiting room and presence of toys for children are also some initiatives that the management of this clinic took for designing their service with the high involvement of visiting patients.

Wards and Corridors: While designing the service delivery process for the patients, the CEO made sure that the wards and corridors of the clinic are kept clean and empty of any furniture except when necessary. One of the patients interviewed regarding this initiative is reported to have said:

“Out of many clinics that I have visited, the best thing I like about this clinic is that they have no seating areas in the corridors. So, when I go to my appointment with the GP, I am comfortable that I have privacy, and no one would disturb me during my consultation.”

Another patient responded to this initiative as:

“*My mother has been admitted to this clinic for renal dialysis and diagnosis for 2 days, I am so grateful that there is no seating arrangement outside her room in the corridor. The last time she was admitted to a public hospital (for other reasons), she could not sleep at night because patients and visitors kept on making noises outside her room."*

The management of this clinic understands that the incoming patients have special needs and even a minor problem can agitate a patient as they already don’t feel well, hence, the management tries their best to keep the area next to private rooms quiet and clean.

Appointments: Clinic-B offers online registration and booking for appointments. The patients can also book an appointment by calling the reception of the clinic. A detail of these services was acquired from a receptionist in Clinic-B upon an interview with the researcher. She described the services as;

"Here in this clinic, we understand that time is of value to every person. Nobody likes long waiting times and to avoid the rush, we offer bookings for an appointment over phone calls and through our online website. Visiting patients also have the option to book for consultation from the reception and we try our best to fit in a slot for these patients. This helps in reducing the waiting time significantly."

High patient involvement is observed by the researcher regarding the 'doctor-on-call' service that this clinic is providing. This is a fairly new service for patients who have mobility issues, problems with the conveyance, or special needs. This is further explained by Dr. Usman who works in the clinic and goes for outcalls when required:

"…As you are aware that a significant number of patients who visit the clinic have mobility issues and sometimes, they find it difficult to visit the clinic because of problems like transportation. We conducted a survey around 3 months ago and a lot of patients responded positively for us to initiate this service for our regular patients…"

To understand the findings of service design and patient involvement and innovation in Clinic-B, the services provided must be categorized into 5 different elements. The step-by-step detail of the service design with the element of 'presence or absence' of patient's involvement will construct a clear picture of the services of the studied clinic and will shed light on the depth of research that contributed to the demonstrated findings. The details of the provided service are as followed:

A. Emergency Services
B. Clinical Services
C. Medical Testing Services (Laboratories)
D. Surgical Services
E. Catering Services

A. EMERGENCY SERVICES

'Emergency services' is one of the integral components of Clinic-B. A fully functional emergency ward is operating in the clinic to facilitate all medium-risk emergencies. The researcher observed a high level of patient involvement in the service design of these services with the first observation arising from the fact that this clinic realized the demand of patients to be provided with a 'setup' that provides better quality of services than the public medical sector of Pakistan. Detection of the existing gap in the market and providing a better alternative gives a strategic advantage to Clinic-B in creating mutual value with the visiting patients. The observed involvement of patients in the service design was confirmed through interviews with several patients who felt satisfied with the services they expected from this clinic and how a reliable emergency care unit addresses their concerns.

Another significant step that the management of Clinic-B took due to patient involvement in the service design is the introduction of ambulatory services for emergencies. The researcher was informed by the CEO of Clinic-B that the clinic did not have an ambulance at the time of the startup of this business but due to the feedback and suggestions from many patients, the management of Clinic-B decided to incorporate this service into their service design. The observation in this regard is the patient involvement in 're-designing' of a pre-designed service, which implies that value cocreation can be achieved if the concerns of patients can be recognized and addressed, even if it requires a complex and long process of re-designing a currently provided service. However, it is necessary to mention that the availability of ambulances in clinical setups is not common in Pakistan (EMRO, 2021), and it shows how much the management of this clinic is willing to involve patients for mutually creating value and building a strong retentive relationship.

One more amendment in the service design of emergency care was observed after many patients informed the management about their expectations to ensure the presence of a surgeon/doctor on the premises at all times (when a patient is being treated). The management of Clinic-B responded to the involvement of patients positively and has since ensured the presence of at least 1 doctor at all times, to cater to emergency care.

It is worth mentioning here that Clinic-B is based on a smaller setup than a properly functioning hospital, thus unable to treat high-risk emergency scenarios. Patients are aware of this fact and are informed about the detail of the emergency services provided through the 'Facebook page' and official website of the clinic. An interview with the CEO, explains the difference between medium-risk and high-risk emergencies:

"Medium-risk situations that this clinic caters to are those that have a very low probability for loss of life. The situations treated here are, though emergent in nature, but most are to treat unbearable pain or perform non-life-threatening surgeries. Examples include labor, bone fractures, deep wounds (non-criminal), uncontrollable bleeding, appendix surgery, and similar medium-risk situations. Examples of high-risk emergencies that are not treated here include heart attacks, bullet wounds, organ transplants, cancer therapies, and neurosurgeries. For high-risk scenarios, we advise the patients to visit hospitals that have proper staff and equipment to deal with such situations".

To provide emergency care to the visiting patients with the observed high level of patient involvement, Clinic-B has taken several measures and follows a strict code of conduct with all the processes involved. The list of the primary emergency services, acquired from the CEO of Clinic-B, are as followed:

- Availability of a clinic ambulance and 2 drivers who can bring the patients to the clinic on an emergent basis.
- Presence of paramedic staff in the emergency care unit who are trained to tackle emergencies
- Duty of 'Head-nurse' to check all the equipment and machinery in the emergency ward on daily basis, which includes checking the proper functioning of machinery, availability of Life Saving Drugs (LSDs), and level of oxygen in the cylinders. It is mandatory to deliver this report to the COO of the clinic before noon on daily basis. In case of a problem, the technical team is called on urgent notice to troubleshoot any bottleneck.
- Uninterrupted power supply to the emergency ward via backup power generators.
- Availability of at least 1 general surgeon at every time is ensured to treat emergency patients.

B. CLINICAL SERVICES

The clinical services provided by this PPMC have 6 sub-components and will be discussed in detail in this section. They include:

1. GP services: The service design of General Practitioners has been planned with a lot of consideration by the management of Clinic-B. The researcher observed that the CEO of Clinic-B regarded patient involvement in hiring professional GPs with a good reputation and keeping their number high so that the waiting times of patients could be reduced. The apparent openness and willingness of the management of Clinic-B, to match the needs and service attributes to develop a value proposition, is based solely on the initiatives of service customization.

In terms of innovation in the service design, the management of Clinic-B initiated the process of calling visiting doctors (Locum) in emergencies or when the staff goes on leave. In essence, the innovation taking place generates indirect value creation, in which the management of Clinic-B is using matched operant resources to innovate value propositions and service delivery processes and thus generating novel mutual value creation with their patients. The COO of the company elaborated on the Locum initiative as:

"I came across some patients who mentioned the shortage of staff on some occasions. As a result, the management of our clinic held a meeting in which we agreed upon assigning Locum duty to the visiting faculty. Under this initiative, we call for doctors in the situations when our staff goes on leave or call in sick… To maintain a good quality of GP services, we have already interviewed and selected a few (Locum) doctors, whom we trust to call upon need".

To understand how the management of Clinic-B has incorporated patient involvement in the service design the researcher held several interviews with the top management of Clinic-B. The acquired information is presented below which shows the service structure of Clinic-B regarding the GP services:

The hierarchy of this PPMC demonstrated 7 GPs providing their services. Out of the 7 practitioners, 2 are also taking care of this institution as a company CEO and COO. The rest of the 5 doctors have been hired according to their experience and level of

expertise. The minimum criteria to work in this clinic requires the doctors to have an MBBS degree, which is awarded by the 'Pakistan Medical and Dental Association' (PMDC) upon completing 5 years of education and 1 year of practice as a House Officer (HO). On top of that, the clinic requires the doctors to have a specialization in at least 1 of the necessary fields; general surgery, dermatology, pediatrics, orthopedics, and/or gynae. As of now, the clinic has doctors belonging to all the specialized skills.

A total of 3 lady doctors and 5 male doctors provides GP services from 9 am to 10 pm in their respective shifts. Their shifts are always rotated to ensure the presence of 1 surgeon in emergency care (24/7).

The clinic ensures the presence of visiting doctors (Locum) in cases when doctors are on leave or there is a shortage of medical staff.

2. Pharmaceutical services: The important information taken from the interview of the clinic's pharmacist revealed the fact that the operations of Clinic-B commenced without a dispensary or pharmacy in the first quarter of being functional, but the management respected the wishes of their patients and decided to outsource the pharmacy set up inside the clinic for the ease of incoming patients.

Patient-driven innovation and a strong focus on patient experience are the two factors that led to the service designing of pharmaceutical services in Clinic-B. As most of the clinics operating in Pakistan have their own dispensaries, the newly established or under-performing pharmaceutical companies follow the practice of sending their salespersons to these clinics, offering gifts or financial benefits to the doctors to promote their medication (Mustafa et al., 2018). In contrast to this practice, the management of Clinic-B believes in proper and certified medication for their patients rather than generic medication, hence, the decision to not include a clinic pharmacy in the initial service design was intended to gain the trust of the visiting patients. The management intended to assure the patients that this clinic would not compromise on quality over financial benefits and the doctors would only prescribe medicines that can be bought from a licensed pharmacy. The CEO is reported to have said that:

“We take pride in providing quality medication to the visiting patients. There is not even a single prescription that is written in this clinic that contains unbranded medicine”.

A survey regarding the need for a pharmacy inside the clinic's premises was conducted by the top management of Clinic-B in 2017. The opinions of various patients were recorded and analyzed to come up with a decision regarding the opening of a pharmacy. The patients visiting Clinic-B, mostly belonging to the upper class of society, had awareness of the disadvantages of clinical dispensaries and hence they provided alternative ideas for the clinic to allow a franchise of a renowned pharmaceutical company to be established to ease the patients with buying medicines after a checkup.

It is due to the patient involvement that the service design of Clinic-B was constructed to provide the availability of a 24/7 pharmaceutical franchise that is located in the premises of the clinic. There is a total staff of 5 pharmacists providing their service throughout the week. The shifts are rotated in morning and evening shifts. The presence of 3 pharmacists is made compulsory due to the number of patients visiting the clinic on daily basis. The pharmacy is a franchise of a famous company whose network is spread throughout the country and possesses an ISO certification for the quality of medicines that are dispensed to the patients. According to the researcher's observation and the interviews conducted from the dispensing staff, the following set of duties are assigned to the staff for them to provide their services effectively;

- The first and foremost duty of pharmacists is to keep a check on the medicine inventory and order stock on time to avoid a shortage of medicines. Further duties include the arrangement of medicines in alphabetical order to help reduce the waiting time of patients and stacking the short expiration medicines to the front to avoid the operational cost. The difference, in this case, is that personnel working in the pharmacy sell medicines through the pharmacy's software that allows them to monitor inventory with more efficiency, and data is automatically stored in the company's central cloud storage.
- Pharmacists in this clinic do not have to maintain a register for all the dispensed medicines. The software links patient names, prescriptions, and GP instructions, hence an electronic record is automatically created which also helps in reducing

prescription errors leading due to handwritten prescriptions or problems in cases of lost prescriptions.

- All the payments received by the franchise are collected by the pharmaceutical company and the pre-agreed percentage of net sales is transferred to the clinic.
- As part of the services by the pharmacy are outsourced to the pharmaceutical firm, Dr. Sadaf does not have to order any stock herself.

3. Nursing Services: For any clinic to work efficiently, the quantity and quality of nursing services are crucial (Gull. B, 2008). The researcher observed patient involvement in the service design of all nursing-related services in Clinic-B to be quite high. Concerning SDL literature discussed in the previous sections, the nursing staff in healthcare clinics play an important role in mutual value creation. As for the case of Clinic-B, the top management has made sure that this vision is spread all across the hierarchy and that the hired nurses understand the significance of mutual value creation with regard to the visiting patients. It has been observed that the value creation amongst the 2 actors (patients and nurses) is usually unfolding, over time, with a consequence of continuing a social and professional exchange, relational norms, and exchanging competencies. It is seen that from the drug administration, wound dressing to the emotional wellbeing of the patients, nurses play a big role in creating MVC. A higher number of female nurses (than initially intended by the management) were hired in Clinic-B because the female patients felt more comfortable acquiring services from a female nurse rather than a male. Moreover, the presence of one nurse in the wards at all times, is part of the service design, actually proposed by the patients visiting Clinic-B. One of the interviewed nurses is reported to have said:

"Dr. Sadaf (CEO) immediately ordered the HR and Supply Chain department to order 2 workstations to be placed in both general wards after the patients advised the management to ensure the presence of at least one nurse in the wards at all times. Since then, there is always one nurse present in both wards to assist the admitted patients".

The hierarchical structure of Clinic-B highlighted the presence of 8 nurses providing their services in this clinic, out of which 5 are female nurses and the rest are male. As the qualification level of nurses was discussed in the first case study that is explained by (Gull. B, 2008), all hired female nurses are Lady Health Visitors (LHVs). Nurses in

this clinic provide services in 3 different departments namely, clinical, surgical, and emergency services. This will be discussed in detail under their role and duties in each department.

Clinical Services by Nurses:

- The clinical services of nurses include assisting the GP with proper treatment of the Patients.
- In case an injection or medicinal drip is prescribed, the nurses are instructed to administer them with proper care and hygiene.
- Nurses in this clinic are required to be adept in giving Intravenous (IV) and Intra-muscular (IM) injections, testing blood pressure, and testing blood sugar levels.
- All nurses are expected to assist medically disabled patients throughout their stay in the clinic.

Surgical Services by Nurses:

- Nurses are required to assist in the surgical procedures i.e., sterilizing tools, mobilizing patients in and out of operation theatre, and contributing to all the general surgeries taking place in the clinic.
- Female nurses (LHVs) are responsible for maternity care, assisting in normal or cesarean deliveries and post-surgical care.
- Nurses in Clinic-B are not trained for providing local anesthesia and any action before the permission of relevant GP is forbidden to avoid any patient mishandling. Only trained GPs provide anesthesia to the surgery patients.
- Further services include assisting post-surgery patients to toilets and providing medicines/medicinal drips on time.

Emergency Services by Nurses:

- The duty of the head nurse is already discussed in the emergency service section, which is about checking and maintaining the machinery and medicines present in emergency care.
- Nurses working in an emergency have been trained by the relevant staff to perform CPR and life-saving techniques in case of an emergency. They are expected to be adept in handling all the equipment in the emergency ward to perform their duty efficiently at the time of need.
- The presence of nursing staff is mandatory in emergency care at all times.

4. Services By Receptionists: The researcher contacted the COO of the company to investigate if the patients were involved in the designing of reception services provided to the incoming patients. The COO shared a detailed series of events after which the management decided to design and improve the reception services being provided to the patients. Some key points from the interview as mentioned:

"To provide the best services to the visiting patients, the management of Dr. Sadaf's clinic conducted a survey after 6 months of being operational. One of the key points of the survey was to determine if the patients wanted the clinic to hold their medical records and history for the ease of future treatment. The majority of patients showed consent and also requested a service through which they can obtain copies of their medical histories in case they preferred to change the clinic or for any personal reasons. Due to these findings, the management of this clinic trained receptionists to provide the medical records to patients from the available computers and printers provided at the reception".

The COO also mentioned some key attributes which the patients expected from the receptionists working in Clinic-B. These include good and positive behavior of staff working at reception, restriction on the usage of their mobile phones and being professional and quick with their jobs. The management and HR department of Clinic-B considered all suggestions and designed the services according to the wishes of incoming patients.

The list of services for the receptionists is mentioned below:

- The services of receptionists include registering the patients and saving their medical records in the company's database.
- To greet the patients with the best behavior and assist with all the necessary information a patient requires
- Receptionists are also responsible to provide the medical history to the patients if they request them. For that purpose, equipment including computers and printers are available at the reception desk.
- Laboratory Receptionists are both registered radiologists and carry all medical testing in the labs along with keeping data and dealing with the patients.

5. Janitorial And Housekeeping Services: Janitorial services are one of the most crucial services, designed with the help of patients' involvement. As the patients visiting Clinic-B are very aware of cleanliness and hygiene, they expect the clinic to be in a clean and hygienic state to avoid any contamination of diseases. One member of the janitorial staff explained to the researcher about the measures taken due to the patients' involvement in the service design in the following words:

“The patients coming to the clinic reported to the admin about cleaning and disinfecting the patient’s waiting area frequently. The management in return has assigned us the duty to disinfect all the leather seats, armrests, and doorknobs after every 2-3 hours. To ensure the practice, we have been provided with a company book in which we have to record the time before and after the cleaning. The book is checked by Dr. Javed (Admin) on weekly basis".

A similar practice is observed with the housekeeping services where the patients expected the staff of Clinic-B to change bed sheets every day and the clinic ensured the practice by adding this duty to the job role of the janitorial staff. The list of services designed for the janitorial staff are as followed:

- Janitorial staff is assigned to clean throughout the clinic during their shifts. The 2 shifts run on a morning and night basis and the presence of 1 staff member is a compulsion.
- Special instructions on the use of company-approved cleaning material are exercised and all the touchpoints are cleaned after every 2-3 hours. Examples of touchpoints include doorknobs, toilet taps, and patients' seating areas.
- Janitorial staff is responsible for maintaining and recording the stock in hand and in case of a need for more supplies, the janitorial team is advised to inform the clinic's admin, Dr. Javed, 2 days in advance.
- Housekeeping service (as referred to in the clinic) is specifically designed for the priority private patients and the patients admitted in medical wards. The service includes cleaning the toilets, changing bedsheets, and replacing daily use items every day.

6. Security Services

As the concept of indirect value has already been discussed in the findings section, an observation in this regard was noted by the researcher related to the security needs of the visiting patients. Clinic-B's management was observed to be proactive when it came to providing security to the patients. The service design of security services is understood to establish and deliver a sense of 'personal safety' and 'safety of belongings' to the visiting patients. Due to the provision of a carefree environment, the patients are observed to be recipients of indirect value from the clinic and hence seen as actors 'highly' involved in mutual value creation.

An example regarding the high ability to customize services was also observed regarding the security services of Clinic-B. It was noted by the researcher that 'quick responsiveness' and innovation are the tools that this clinic has used to create mutual value creation with the patients. During an interview with the security guard of Clinic-B, the guard mentioned a past incident where a patient was robbed in the parking area of the clinic. The management of Clinic-B hired 2 additional security guards right after

being informed by the victim patient and also hired a private security company to monitor the premises at all times. All of these measures were promptly taken, and the patients were notified of the actions through various modes of communication (digital and verbal). The service design that was finalized and still in practice is described as followed:

- For security services, 4 security guards are hired by the clinic. 1 guard is stationed throughout their shift in front of the main entrance and one in the patient's parking area.
- In case of a serious security breach, the clinic has acquired membership of a private security firm which responds within 5 minutes when the alarm is raised.
- To improve the security measures, surveillance cameras are installed at every place in the clinic. The live footage is monitored by the outsourced private security company.

C. MEDICAL TESTING SERVICES (LABORATORIES)

The medical testing services in Clinic-B comprise; blood tests, urine, sputum, biopsy, X-rays, ultrasounds, color doppler tests, MRI, and CT scans. The laboratory services are available to all patients regardless of their treatment being conducted in this clinic or not. The management of Clinic-B believes in 'forward-integration' of processes and services. For that reason and on the demand of visiting patients, the clinic inaugurated a fully licensed pharmacy along with a laboratory to conduct routine tests inside the premises. One of the patients interviewed about the presence of lab and pharmacy in the clinic is reported to have said:

"I would say this clinic understands the patient's problems and pay heed to the requests made by us. I was part of a survey that was conducted a few months ago, I stressed the need of having test-laboratory here to ease the patients from going somewhere else and bringing those reports to the clinic for diagnosis. Not only do we have the comfort of an inbuilt laboratory but also a pharmacy where we can buy our prescribed medicines from…"

From the research conducted in Clinic-B, the researcher came across various pieces of evidence that supports patient involvement in the service design of laboratory services in the clinic. The first evidence is the level of cleanliness that was observed in the clinic's laboratories and the interview responses of the patients regarding the surety of clean and hygienic testing equipment. The other evidence includes the hiring of licensed radiologists with experience and being adept in their line of work. Both of the interviewed radiologists exhibited professional conduct during the interview and shared the systematic approaches undertaken in the laboratories to satisfy the needs of incoming patients. It was observed that the children were dealt with friendly behavior and the radiologists were very patient with explaining the procedures to the children to ensure they do not get frightened at any stage of medical testing.

The services of 2 radiologists are mentioned below:

- Apart from dealing with patients over the laboratory reception counter, laboratory staff is required to clean and maintain all the testing machinery.
- Staff is required to assist the patients in all the medical tests with their best behavior and with a special focus on children.
- The presence of at least one radiologist between 9 am to 10 pm is mandatory
- Staff is also responsible for uploading the patient's results to the patient's profile in the clinic's database.

D. SURGICAL SERVICES

There is practically a lot of patient involvement in the service design of surgical services provided in Clinic-B. As mentioned earlier in the literature section, the government setups in Pakistan provide a low quality of services especially in the surgery department, due to which the patients tend to avail services from private clinics and hospitals for quality healthcare. Patient involvement in this specific case demanded Clinic-B to ensure a hygienic, clean, and reliable environment where the surgeries would take place. The patients expect the clinic to sterilize all the tools and apparatus that would be required for the surgical procedures and reputable surgeons whom they can trust upon. The patients, usually belonging to the upper class, demand

comfortable and prompt post-surgical care irrespective of the costs it would entail. As the utility value for the patients of Clinic-B is more service-oriented than the cost of services, the clinic had to come up with a design that would satisfy the needs of this specific segment of the market. This phenomenon is widely understood by the top management and the COO of this clinic explained it in the following words:

"The patients visiting us in this clinic belong to an upper or elite class which means that they are well educated and well aware of the treatment they expect from us. Our surveys and discussions with the patients revealed that they expect a higher value from the services we provide, and they are flexible with the added cost, given that the care they receive is more than satisfactory. We designed our services to provide them with state-of-the-art surgical setups, specialist surgeons, and a hygienic environment so that they could feel valued in our setup. We also provide them with exceptional post-surgical services and VIP private rooms to ensure their wellbeing and comfort".

The quality of surgical services that Clinic-B provides can be understood by the management's decision to hire GPs with a specialization in any one of the following surgical domains; pediatrics, gynae, dermatology, orthopedics, and general surgeries like appendix, removal of stone from the gall bladder, etc. The availability of surgeons who have specialized in all of the domains collectively provides a competitive advantage to Clinic-B against the other clinics operating in the city. The main services provided in this area are mentioned below.

- The most important service that Clinic-B provides in this department is the guarantee of a clean and hygienic atmosphere where the surgeries take place. Special focus towards sterilization of surgical apparatus, change of disposable equipment, clean and sterilized sheets, and other similar measures ensure minimum chances of infections.
- To ensure the provision of hygienic and clean conditions, the maximum number of surgeries conducted per day is limited to 6. This means that both surgery rooms can be used a maximum of 3 times per day. This practice allows ample amount of time for staff and nurses to disinfect the surgery rooms and clean them properly for the next surgery.
- Clinic-B ensures proper post-surgical care by providing the option to select general wards or VIP rooms for the recovery period. During this time, the doctors

visit the patients frequently and the nursing staff is expected to provide proper care to the recovering patients.

E. CATERING SERVICES

When inquired about the patient involvement in the service designing and innovation process, the respondent (CEO) stated that patients played a vital role in designing the catering services. She mentioned that several patients were inquired about their preferences regarding the catering service in Clinic-B before making the cafeteria operational. The patients responded that they would feel more satisfied given that the meals would go through proper quality checks from the management of the clinic and 'hygiene' would be prioritized throughout the food preparation phase.

As the clinic has been observed to involve patients in the service design, the CEO did everything she could to create value for the visiting patients. In-depth awareness of patient needs led to the outsourcing of the cafeteria to a reputable company. To ensure higher standards and quality of this service, the management designed this service in a manner that included strict quality checks and preparation of the list of approved and prohibited food items. The researcher observed several quality checks on a number of occasions, during the investigation phase. Concerning innovation, the researcher found these quality checks to be 'unique' and subjective to the patients visiting this clinic. However, it can be deduced from the steps that this clinic has taken, that Clinic-B is mutually creating value by their strong innovation and involvement of patients in the provided services.

Catering services in Clinic-B are also outsourced to a reputable private catering company. The services assigned to the company include:

- Providing meals to the admitted patients at any time of the day upon request and catering to all patients and visitors over the counter.
- A fixed list of permitted food items is provided to the cafeteria management to maintain hygiene and avoid food-related problems during the recovery period.

- Quality checks are randomly conducted by the COO of Clinic-B to ensure the food is acceptable and appropriate for the patients and clinic visitors.

5.2.1.2 INTENSITY OF KNOWLEDGE TRANSFER:

The fourth Foundational Premises of SDL depicts ‘operant resources’ (transfer of knowledge) to be the fundamental source of strategic benefit (Vargo and Lusch, 2015). In other words, it can be said that the higher the intensity of knowledge transfer between the provider and beneficiary, the stronger will be the presence of SDL, and vice versa.

While exploring this clinic, some key points regarding the intensity of knowledge transfer between the 'clinic' and 'patients' were observed and noted by the researcher. It is to be noted here that the term 'clinic' is used rather than the transfer of knowledge between 'doctor' and patients. The reason for the use of 'clinic' is understood from the literature explored by Osei-Frimpong, Elg, and Yang who underscored the reality of SDL to be far greater than the 2-actor relationship in a healthcare setup, meaning that the combined role of clinical staff, doctors, pharmaceutical staff and all stakeholders syndicate to cocreate value along with the patient (Yan and Kung, 2018; Elg et al., 2013; Osei-Frimpong et al., 2018).

It is observed that this clinic keeps its patients up to date with all information regarding patients' health, medication, treatment procedures, and progress over time with the use of the 'push' knowledge transfer dynamic. Record keeping along with making a file for every patient are the key factors that are followed throughout this institution to push the knowledge transfer towards the associated patients. This also links with the literature of Yan and Kung who discussed the significance of knowledge transfer between the doctor and patient for the high presence of SDL (Yan and Kung, 2018). The two relevant interviews in this regard, one from a serving GP and the other from a visiting patient complement the intensity of knowledge transfer in this clinic as discussed above. The patient who was interviewed in this regard is reported to have said:

"I am quite satisfied with the information and knowledge shared with me at this clinic. Starting from the GP, I am quite happy with the way he/she explains my diagnosis, precautions, and listens to the symptoms I visit the clinic for. This is my 2nd month of being associated with this organization and since then the clinic has maintained my medical history for all that period. I don't have to carry any reports or history with me as the data is available to the clinic in their online storage system. Moreover, I am supposed to receive an annual report from the clinic detailing my number of visits, progress, and treatments…"

To understand the significance of 'knowledge transfer' from the perspective of this clinic, the researcher interviewed one of the doctors, Dr. Zara, who explained how and why this clinic believes in sharing knowledge with the patients. She explained:

"As it is crucial for us (Doctors) to know exactly what the symptoms are for the patient that we are diagnosing, it is also crucial for patients to receive ample amount of information from our end. A good GP not only believes in physiological treatment but also in a psychological one. We allow our patients to discuss their symptoms/situations with us in detail and we encourage them to ask questions about any ambiguity they might have during or after diagnosis. This helps in building trust between the doctor and patient and also relieves patient psychologically from the worry that there is a chance of any mistake in the treatment they receive."

Both the interviews that were conducted share a common factor which is the transfer of knowledge. The importance of giving ample amount of time to the patients to discuss their medical condition and explaining the diagnosis is highlighted in several discussed studies which were conducted to examine mutual value creation (McColl-Kennedy et al., 2012; Nordgren, 2013).

Further evidence of strong knowledge transfer was observed through data collection within the clinical hierarchy. It was seen that the strong role of HR ensured numerous training workshops, frequent staff meetings, and continuous online communications. These measures were observed to be the reasons for leading the clinic towards better service knowledge, higher service involvement and significantly impacting the value creation process with the patients. Hence, strong knowledge transfers seem to be the plausible cause contributing towards high SDL presence.

5.2.1.3 RELATIONSHIP MANAGEMENT BETWEEN SERVICE PROVIDER/BENEFICIARY

Relationship management (RM) in any organization is one of the key areas to retain customers, build trust and mutually create value. The study of RM between the service provider and beneficiary is quite interesting in the case of Clinic-B as the observations during research indicated a presence of 2 different sorts of approaches taken to build and strengthen this relationship. The researcher came across the 'Direct' and 'Indirect' approaches through which the relationship between Clinic-B and patients is being managed.

The direct approach of RM is seen where the clinic has specifically designed services to create and build relationships with the patients, with the aim of higher MVC and stronger patient retention. All of these services are 'proactive' in nature and emphasize deeper engagement with the patients to better understand their preferences and value perceptions. The services are designed in a manner that ensures cross-functional coordination for value creation via a complex network of inter-related service offerings. Some examples of the direct RM approaches are mentioned below:

The researcher observed a 'system' by which the clinic is creating and maintaining association with all the patients it caters to. Under this system, Clinic-B is seen to involve the use of technology as an aid to simplify and amplify the service criteria and to provide effective communication. The researcher noticed that all the visiting patients are individually informed about their appointments date and the time of visits via the use of the clinic's software. The software purchased from the 'telecommunication network' sends automatic 'text-message' reminders to the patients who have an appointment in the near future and notifies the concerned staff of Clinic-B in case the preferred mode of communication is different than 'tele-communication'. However, the most common method found in this regard is the use of text messages that most of the patients opt for, though other communication methods include letters through postal service, emails, and phone calls. These measures were introduced to build a

stronger relationship in a way that the patients feel ‘valued’ and ‘informed’ throughout their association with the clinic. Dr. Sadaf in her interview explained this approach as:

"To create a professional relationship with patients, we keep the flow of information as easy as possible and use various methods to update them regarding their medical needs. Currently, we are communicating with our patients through text messages, phone calls, emails, posts, and soon we are planning to launch our clinic's mobile phone app which will cater to every patient's individual needs…"

The example provided shows that the management of Clinic-B is proactive in building RM and the service design of all the departments is structured in a way that demands cross-functional coordination of all inter-related service offerings. In this case, from GPs to receptionists and up to radiologists, all the staff have to play their role by updating the patient information to company software efficiently and effectively. This coordination in turn helps the software to maintain communication with the patients for any upcoming appointments or medical tests. Lastly, through all these procedures, the clinic is observed to create MVC and build patient retention.

The second direct approach for building RM is observed from the 'Top Management's Commitment', working to deepen the relations between GPs and patients. Under this approach, the management of Clinic-B is observed to allot the same doctor to the patients, they have been diagnosed with before. This strategy helps in gaining the patient's trust and builds a relationship over time between the service provider and beneficiary upon every visit. In special cases, the patients always have an option to change their GP on special requests/needs.

The third direct approach observed demonstrates the top management's will to ensure all the cultural norms are respected and applied to create a good relationship with service beneficiaries. This has been earlier discussed in the literature review of this thesis that in Pakistan women feel more comfortable by obtaining their treatment from lady doctors. For this purpose, the clinic has hired a female doctor specialized in gynae-related services and another female GP to treat the women who visit the clinic on general health-related problems. The same is the case with clinical staff that is working in the clinic.

Lastly, the researcher observed some strategies through which the top management of Clinic-B is building patient loyalty and rewarding the patients for retaining

relationships with the clinic. The most obvious example of this scenario was noted by the researcher when coming across the '10% discount offer', displayed in the pharmacy, for the patients purchasing medicines over Clinic-B's prescriptions. This strategy can be regarded as a very smart decision by the top management as it benefits the clinic on multiple grounds. The first advantage of this offer is the creation of MVC with the patients who feel valued to be 'associated' and 'financially benefitted' from this relationship. The second advantage can be seen as a financial gain to the clinic's pharmacy, as a majority of the patients who visit Clinic-B end up buying medicines from the pharmacy to avail the 10% discount offer.

The researcher observed various indirect approaches where the clinic has made appropriate 'decision making' and 'organizational alignments' to manage the relationship with the visiting patients. The examples of these indirect approaches can be seen by the Top management's decision to withstand high costs (in money, time, effort) of HR and Supply Chain departments. The HR department, for instance, is providing all the necessary training to the employees to build a strong relationship with the patients and is responsible to instill the vision of the clinic to every employee in the hierarchy. The organizational alignment is helping Clinic-B to maintain high patient engagement with 'in-depth' awareness of patient needs so that the MVC can lead to better retention and patient satisfaction. Whereas the Supply chain department is indirectly building and maintaining the relationship on providing the clinic with up-to-date technology and services which result in creating value with the patients and Clinic-B.

5.2.1.4 TOP MANAGEMENT COMMITMENT

The commitment of top management plays a vital role in embedding SDL into the DNA of an organization. Strong top management ensures effective use of leadership skills that aid in strong SDL presence throughout the organizational culture and network.

In this case study, the researcher came across an organization that is wholeheartedly investing in the market and commits to providing services with a strong focus on value co-creation. To understand the essence of commitment of top management put forward by this clinic, the researcher has elaborated the strategies into three different

genres i.e., Management commitment towards staff, relation-building with patients, and the commitment towards technology/innovation. This is further elaborated in the sub-sections below.

5.2.1.4 A MANAGEMENT COMMITMENT TOWARDS STAFF:

As it is understood that top management plays a vital role in ensuring service quality from their staff and their commitment can impact the net turnover to a high degree (Ashill et al., 2008), Clinic-B emphasizes this principle to satisfy all the patients who visit the clinic for treatment. The HR department of this clinic takes pride in the effective training of all the managerial practices conducted inside the premises. All the appointed employees must attend formal seminars, workshops, and training sessions from the HR department before and after being employed in this organization. This training is mandatory for the medical consultants, general practitioners, admins and even stretches down to the janitorial staff providing their services in the clinic.

"*Right-person-right-job practice ensures the smooth running of our organization. Every person hired in this clinic has gone through multiple interviews and tight scrutiny of their work experience and expertise before we decided to offer them a formal job letter. This shows how serious we are with our services*" (Admin).

The literature review section of this thesis discussed that top management commitment and a strong focus on service excellence does not justify the obvious scenario where the whole organization would have the same mindset. To achieve an SDL-minded approach throughout the organization, the top management must somehow embed SDL into the DNA of the organization. However, the researcher observed the strong HR team of Clinic-B, developing the 'service culture' throughout the organization from effective leadership skills.

5.2.1.4 B MANAGEMENT COMMITMENT TOWARDS TECHNOLOGY AND INNOVATION:

The top management of Clinic-B believes in the use of state-of-the-art machinery and provides advanced technological treatment to their patients. In an answer to a question asked by the researcher regarding the cost of the radiology department, the CEO is reported to have said that:

"*Yet alone the X-ray and sonogram machines have cost us an amount of 3 and a half crore rupees (186,000 GBP). Going for these expensive models has allowed us to provide color doppler tests along with digital X-rays and 3-d Ultrasounds, which to be honest are quite rare all across our country*"

Further interview with Dr. Sadaf revealed the fact that their suppliers are considered equal stakeholders and co-actors in the business network. Due to information privacy, the names of suppliers were not provided though it was mentioned by her that;

"*Our supply chain department ensures a good relationship with suppliers and due to this reason, most of the innovation that you see in this clinic is made possible by consultations and advice put forward from our suppliers. They (suppliers) keep us updated with new and better equipment, whether it is for our laboratory or other departments*"

5.2.1.4 C MANAGEMENT COMMITMENT TOWARDS RELATION-BUILDING WITH PATIENTS:

Several relation-building tactics by the top management have been discussed in MVC dynamics, however, the researcher came across some measures by the top management which is leading towards higher MVC with patients. In one of the interviews with Dr. Kamran (GP working in Clinic-B), he is reported to quote the CEO in the following words:

"*If you manage to remember your patients, you have recurring patients for life".*

The interview with Dr. Kamran demonstrated that the top management is focused on creating mutual value with the patients and for this purpose, they are instilling the vision to all the GPs working in Clinic-B. The management is observed to be proactive by sharing strategies with the GPs and other staff working at Clinic-B.

Another attitude observed by the researcher is regarding the social interactions of top management with the patients. It was detected that the top management of Clinic-B was engaging frequently in social interactions with the patients. Upon noticing this attitude, the researcher inquired the CEO of Clinic-B, who considers 'social interactions' to be significantly important along with the professional ones based only on the healthcare provision or treatment. The CEO elaborated that the social interactions were resulting in deepening the trust and association with the patients and helping the management to overcome factors such as shyness and social barriers.

5.2.1.5 RESOURCE ORIENTATION

As aforementioned**,** the management of Clinic-B takes pride in hiring skilled employees for their organization and considers it as a vital responsibility resting on the top management's shoulder. When it comes to resource orientation, SDL requires a mindset that has its foundation based on operant-centric resources. An increased focus on operant resources is a key driver in shifting towards SDL (Vargo and Lusch, 2004). Highly skilled staff in this clinic ensures the top management sets goals to be achieved strategically.

The amount of standardization or automation observed by the researcher in Clinic-B appeared to be quite 'low'. The staff interviewed demonstrated a deep knowledge of the services required of them by the patients. Staff's understanding of the nature of the healthcare sector depicted considerate knowledge towards the individual needs of patients and hence a behavior of individualized-service-provision was noted by the researcher, instead of a standard protocol towards all incoming patients. An example is this respect, as observed by the researcher, is of a female patient who came for an abdominal ultrasound. Even though 2 patients were queued for the ultrasound test (both of non-emergent nature), the female patient was given priority because her test

required consumption of a copious amount of water before the test could be conducted. The patient was given priority over the fact that it was difficult to hold the urinary bladder for a long time after drinking this amount of water.

The decision to test the female patient first was made by the radiologist, Mrs. Shaheen, without any request put forward from the patient. Application of the right set of knowledge and skills by the radiologist, in this case, shows a trend towards operant centric approach as compared to operand one. It shows high adaptability for learning, which in this case was due to hiring someone with good skills and secondly because of long work experience.

Another example of the presence of skilled staff in Sadaf Clinic can be extracted from an interview of the researcher with the pharmacist working at this clinic. Mr. Sehrosh who is a licensed pharmacist briefly explained his experience of working in this clinic. While answering one of the questions he was reported to have said:

"*Once in a month or two, there is a slight likelihood that a doctor would prescribe medicine to a patient which is not related to the patient's problem or is merely a result of typing error, in these situations my knowledge in pharmaceutical dispensing has helped me to identify and report the medicine to the concerned doctor/s. The problem, whatsoever, is straight away rectified"*

5.2.1.6 SERVICE ORIENTATION

The service orientation of Clinic-B is observed on three components as described in the SDL presence framework:

a. Focus on Patient experience
b. Focus on Relation building and care provision and
c. Patient Orientation

The use of operant-centric resources has enabled Clinic-B to exhibit a strong focus on patient experience. The clinic's vision to satisfy the visiting patients has led to the strategies that are strictly followed to create a high level of MVC between service providers and beneficiaries.

The first element that the researcher observed regarding patient experience was the behavior of receptionists with the visiting patients. It was observed that the receptionists were exhibiting friendly behavior and greeting the patients with a very positive attitude upon arrival to the clinic. From the process of patient registration to being called for consultation with the GP, all processes were being conducted in an oriented manner. A fully air-conditioned clinic played a vital role in this regard and it was observed that the patients waiting for their turns remained calm and satisfied. To further improve the experience, the management of Clinic-B was seen to have provided an ample amount of seating arrangement in the clinic so that the patients always find a seat while waiting for their turn to be examined by the GP. The throughput times for patients to be examined by the GPs are kept low by the already discussed service design. Lastly, the post-clinical and post-surgical services devised by the management are carefully designed to ensure the patients remain comfortable throughout their visit to the clinic. It was observed that the clinic was accommodating all the patients with a high level of professionalism and keeping the patients satisfied for an exceptional experience in the clinic.

The second component observed revolves around 'relationship building and care' and to build a strong relationship, in this regard, the receptionists were seen to be providing feedback forms to every patient who was visiting Clinic-B. These measures were being taken to realize if the care provided to the patients was up to their expectations or if the patients were unhappy due to any reason. The valuable feedback or complaints were seen to be collected in the designated glass box placed on the registration counter. As aforementioned, a common practice was observed by the researcher in the clinic in which the management personnel was observed socializing with the patients and inquiring about their experience about their visit to the clinic to further build on to the relationship. As the evidence suggests, the researcher found this practice leading to accommodative service orientation and eventually aiding in higher MVC with the visiting patients.

In terms of observing the ability to customize services for the patients, the researcher came across a unique practice that has not been highlighted in any of the explored articles in this study or experienced by the researcher himself in Pakistan (as the researcher has resided himself in Pakistan for 25 years). It was observed that the clinic was offering in-call doctor visits to the patients associated with Clinic-B. This practice

is evidence of a 'high ability' of Clinic-B to customize services for their patients and is designed for the patients who have mobility problems, giving them the option to opt for an in-call doctor visit. Although there are some requirements for this service which include extra cost and qualifying criteria, still it is very helpful for old age patients or ones suffering from a disability.

The above findings indicate that Clinic-B has an accommodative service orientation towards all the patients it caters to.

5.3 MUTUAL VALUE CREATION

As this is a study of dyadic relationships, it makes sense to observe value creation from the perspective of both the service provider (Clinic-B) and the patients, in short: *mutual value creation*. In doing so, the author has drawn on the conceptualized mutual value creation logic developed from existing literature as discussed in the previous chapter. From strong management commitment, use of operant-centric resources, and a strong focus on patient experience to the high involvement of patients in service design, intense knowledge transfer, and individualized relationships, all components are leading towards mutual value creation. The three types of values considered for the determination of MVC, in this case, are categorized as: technical, financial, and perceptional value.

To analyze the MVC in Clinic-B, the researcher conducted interviews with the management and patients of the clinic. The factors observed for analyzing MVC in Clinic-B are presented in the pie chart below and the reason for choosing these factors will be discussed in detail while discussing the mentioned 3 types of values:

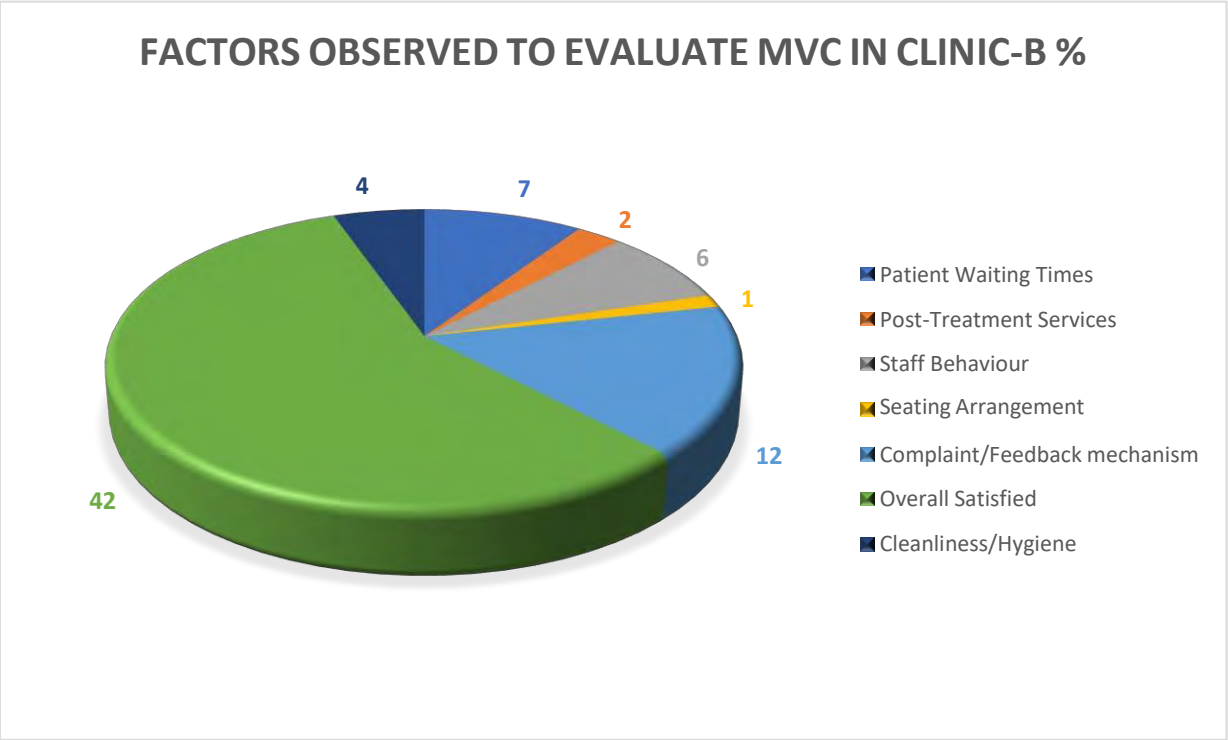


Figure 5.4: Factors Observed to Evaluate MVC in Clinic-B

The factors observed to evaluate MVC in Clinic-B include cleanliness of the clinic, behavior of medical staff, waiting time for consultation with GP, seating arrangement, post-treatment services, overall satisfaction, and complaint/feedback mechanism. Detail is as followed.

5.3.1 CLEANLINESS/HYGIENE

A small percentage of 4% of patients showed dissatisfaction regarding the cleanliness and hygiene maintained in the clinic. Although the majority of the patients had very positive feedback, some patients showed concern regarding the cleanliness maintained in the patient-accessible toilets. One of the interviewed patients is reported to have said:

"I am not saying that I am not impressed by the overall cleanliness kept in the clinic but on a few occasions, I have noticed that the patient toilets are not properly cleaned, or the frequency of cleaning was not high. I know other patients are to be blamed for

not being considerate for the next user but still, I found discomfort in that area. Apart from that, I cannot find any reason to doubt the hygiene maintenance in this clinic".

This response gives an insight into the value perception of patients visiting Clinic-B. It shows that the patients are accepting of the clinic's effort in maintaining cleanliness and are considerate of the fact that other patients can be a reason to become a bottleneck for the company to efficiently deliver their services. Such degree of trust only comes after a good experience on several occasions where patients/customers begin to reason, in case of a bad experience or an event that is lower than their expectations.

To observe the surgical standards of Clinic-B, a special request was made to visit the operation theatre/surgery room. The difference from other clinics, however, was quite evident and the care taken in handling surgical tools was nothing less than 'impressive'. Photograph A below shows the surgery room of Clinic-B which shows all sterilized surgical tools kept inside the surgery tray (on the extreme right corner of the room) and a clean environment to perform all surgeries.

Photograph A: Reflecting the hygiene conditions of Clinic-B

5.3.2 BEHAVIOR OF STAFF

Out of 200 patients who were interviewed, a total of 6% showed dissatisfaction towards the behavior of staff. This is, considerably, a very low percentage of people who encountered any problem in this specific area. Upon interviewing, a few reasons were discussed by patients regarding this problem. One patient is quoted to have said:

"The receptionists over the main reception were having a problem finding my medical history and just because it was a busy time, they wanted me to come back at another time which was not feasible for me. Fortunately, the admin of this clinic paid a visit and helped to resolve the issue. I expect better behavior from all the staff working in this clinic, although the behavior of admin was quite helpful, the behavior of receptionists could be more cooperative too".

The other patients interviewed had some minor issues that led to the dissatisfaction with the service they received but none of them reported repetitive bad experiences in this clinic. This shows that even though problems do arise in the service delivery of Clinic-B, actions are also taken to rectify the problems immediately.

5.3.3 WAITING TIME

Waiting time of patients has the highest percentage of dissatisfaction experienced by the visiting patients. A total of 17% of interviewed patients had to wait for a long time on one or more occasions to be checked by the doctor.

It is discussed in the services section how the clinic minimizes delays in the busy times but occasionally a lot of visiting patients with no pre-booked consultation visit clinic and adjusting the appointments for these patients cause delays in the services provided. The COO of Clinic-B was interviewed regarding this issue and is reported to have said:

“Since the beginning of the operations in this clinic, our goal is to minimize the patient throughput times but the occasions like; abundance of patients without pre-booking or need of more than 2/3 doctors in the emergency ward results in the delays causing

variations in the waiting times of patients. We are working to solve this issue by redesigning our services structure and hopefully will be able to find a sound solution".

5.3.4 SEATING ARRANGEMENT

The lowest percentage of 1% of patients found seating arrangement to be a factor of dissatisfaction or lower value creation in Clinic-B. The clinic plan shows an abundance of seats allocated in every corner of the clinic to facilitate the patients. Out of all the interviewed patients, none of them showed dissatisfaction over the number of seats present in the clinic. According to their experience, not finding a seat has never been a problem in this clinic. The 1% of patients who complained had a problem with the seating arrangement designated for patients with infectious diseases. A family of 3 people visiting Clinic-B was interviewed regarding this problem and they responded as:

"We do like the idea of secluding patients with contagious diseases, but the implementation of this idea has not been good so far. On several occasions, we saw people with influenza or measles sitting in the general seating area and the staff did not take any action to relocate them to the assigned seating area. Moreover, patients with different types of contagious diseases sitting in the same section also make them vulnerable to one another so this factor does not make any sense to us".

This family pointed out some valid observations during their visit to the clinic and the researcher decided to include this perspective in the study. An interview with one of the GPs, Dr. Usman, was conducted in this regard and he is reported to have said:

"…We will try our best to train our staff to politely assign the patients with contagious diseases to their assigned area. For this purpose, HR will be requested to train all the staff to politely relocate the patients, so that this issue can be resolved. For the second issue, there is not much that can be done principally. As the hospitals/clinics are the places only visited by the ill (carrying disease in most cases), the best that can be done is to segregate the contagious disease-carrying patients with the other ones. We

will raise this issue in our next board meeting to see what can be done regarding this matter" …

Again, a positive response was observed from the employees of Clinic-B, and the will to accommodate patient expectations was also recorded by the researcher. Photographs B and C are examples of how the seating area of the clinic looks like. These photos are taken in the laboratory waiting area of the clinic.

Photograph B: Waiting room in the laboratory area of Clinic-B

Photograph C: Waiting room in the laboratory area of Clinic-B

5.3.5 POST-TREATMENT SERVICES

Post-treatment services are one of the key areas where Clinic-B is investing and cocreating value in. Only 2% of patients showed dissatisfaction with the services they received in this domain. This low percentage is the result of proper follow-up plans designed by the clinic for all the registered patients. Details of the post-treatment services will be discussed in the SDL presence framework of this chapter.

5.3.6 COMPLAINT/FEEDBACK MECHANISM

12% of the interviewed patients showed dissatisfaction over complaint or feedback mechanisms. The current system of providing feedback/complaints is either via posting a letter to the clinic, writing the complaint/feedback, and sliding it inside the designated box present over the reception or doing it online on website or Facebook page.

A majority of interviewed patients were happy with the methods of providing feedback but showed their concern over the communication regarding their feedback. One patient on this issue said:

"Providing feedback online is a very good initiative by this clinic. I had an option to anonymously send my feedback or provide my details for future communication with the clinic. This I believe is a very encouraging tactic but even after choosing future communication, I did not receive any feedback from the clinic. I am not suggesting that my feedback was ignored but a reply would have given me more value than I received".

The overall percentage still suggests that the current mechanism is working for the clinic, but future interventions would yield many positive outcomes and higher cocreation of value for both the patients and the clinic.

5.3.7 OVERALL SATISFACTION

An interesting percentage of 42% was observed for the patients who felt completely satisfied with the services of Clinic-B and had never encountered a problem throughout their association with the clinic. A high level of cocreation of value and exchange of competencies guarantees such a higher percentage outcome. These patients showed a high amount of likelihood visiting the clinic again if need be and complimented on the services the clinic is offering. A patient admitted in the private VIP room of Dr. Sadaf clinic shared her experience that:

"I am 100% satisfied with the services of this clinic. The amount of cleanliness, care, and comfort that I have received in this clinic is beyond expectations. Staying in my room feels more like staying in a 5-star hotel rather than a medical clinic".

Technical value

The technical value, in this case, can be understood in terms of efficiency and effectiveness, which has a mediating effect on the consequential financial and perceptional value benefits (positive or negative) for both actors involved in the service exchange. In this context, efficiency relates to the throughput times of patients consulted, the effort required to perform these processes, the capacity of processes to perform at (or close to) stated performance parameters, and the utility of operant resources (in terms of application of knowledge and skills).

As far as effectiveness is concerned, it relates to the extent to which value proposition, and the means by which it has been implemented, attain the service exchange objectives set by both parties.

The technical value in Clinic-B reflects an interesting interplay of the efficiency and effective dynamics of service exchange activities. In terms of Clinic-B, accommodative service orientation is observed towards the patients of this clinic, reflected in the eagerness to customize value proposition and the provision of highly customized service delivery processes. Similarly, exchange effectiveness is observed as an outcome of highly focused management orientation by both parties (use of the customized services). This can be seen as the measures taken by the clinic to offer

customized services to the patients, for example, offering advance bookings through phone or website, and the patients, in turn, implementing these measures in this dyadic relationship to create MVC. The utility of the value proposition is seen to be supplemented by the intense integration of the operant resources, provided by the participation in service design from both parties jointly engaged in process innovation from the reception to post-clinical stages incurring inside the clinic. Consequently, the main focus of exchange activities is seen to be related to the cocreation of technical value (involving innovation), which resembles the co-specialization of resources to provide the patients with an effective model on which the patients are provided with enhanced value propositions.

Concludingly, it can be said that both the service provider and beneficiaries are involved in creating MVC by effectively and efficiently exchanging competencies through the services designed, resulting from the combined efforts to design those services.

Financial Value

The financial value for Clinic-B is seen as achieving the return on the investments made on this clinic. The researcher observed that the management of Clinic-B has had already invested a lot in the provision of their services and was prepared to make further financial commitment in terms of operant resources. The interviews with the CEO reflected that the return on these investments was measured in terms of the achievement of budget targets for operating the clinic. The management of Clinic-B was not prepared to disclose the exact financial figures on ROI due to company privacy, but it was disclosed that the results were positive, and the ROI targets were being achieved.

Alternatively, the financial value of the patients associated with Clinic-B was recorded to be less inclined towards the cost benefits and more towards perceived value. This will be discussed in detail in the perceptional value category to how the patients determine the value in Clinic-B. Moreover, the financial benefits, such as the one discussed earlier regarding 10 % off on medicines, are seen to be of intrinsic value to the visiting patients and serve both the clinic and patients at the same time to create MVC.

Perceptional value

The most interesting dimension of value is noted to be 'perceptional value' when it comes to the service beneficiaries and provider. Again, due to the dyadic relationship observed, the perceptions of patients and the clinic combinedly give way to an environment where the value for the clinic comes from the perceptions of the patients, and the value for patients is taken from how well they are 'treated' by the service provider.

The factors discussed above, which include, satisfaction regarding waiting times, the behavior of staff, cleanliness, feedback mechanism, and post-treatment mechanism, all result towards shaping positive perception for the patients to be associated with this clinic. The elements like trust and ease of interaction are seen to be building with the patients and the utility of such benefits is recorded to increase over time.

The findings on the perceptional value of Clinic-B opens a new avenue in the literature as SDL is observed to be contextual, and MVC is observed as coming from both parties.

5.4 COMPARISON OF FINDINGS WITH REGARD TO VALIDITY

As the researcher has presented the findings from both private healthcare clinics in chapter 4 and 5, an important realization has come to surface. Although the findings (Clinic-A and Clinic-B) are not exactly polarized, the significant differences in the findings, suggest that Clinic-A challenges the initial propositions quite strongly. This means that the low presence of SDL has been seen to have a lower impact on the patients when it comes to availing the healthcare services from the clinic again. This goes against the notion that lower presence of organizations can lead to lower patient retention and weaker relationship orientation. These findings can have a drastic impact on the validity of inferences made and therefore, it is important to understand how the findings of Clinic-A challenge the theory of SDL in the healthcare practice of Pakistan. For this purpose, the researcher is going to observe the factors that have been used to evaluate mutual value creation in Clinic-A as compared to Clinic-B. At this point it is quite logical to include a section in the Discussion chapter

that evaluates MVC in healthcare clinics based on the service cycles such as; point of reception, diagnosis, medicine dispensing, point of closure, etc.

CHAPTER 5 – FINDINGS SUMMARY
• This chapter began with providing the details of Clinic-B i.e., its background, number of employees and the floor plans • The researcher attempted to map service design of Clinic-B and provided details to all the services that this clinic provides to its patients • It was found that the patient involvement in the service design was quite high, especially when compared to Clinic-A, and there were number of services that were offered mainly as per the requests of visiting patients • Findings suggest a high transfer of knowledge between all the actors involved and the use of technological resources (websites, text messages etc.) is seen to increase the flow of knowledge for the visiting patients • Findings suggest that the relationship management of Clinic-B is systematic and entrenched deep into the company culture. Top management and staff are seen to be keen on building long term relationship with the patients • The role of top management is seen to be focused on providing quality services to the patients and building stronger relation. Therefore, cost of treatment is found to be higher in this clinic as compared to Clinic-A • Accommodative service orientation and high reliance on operant centric resources are the two main findings that came up from exploring this clinic • Value perception of the visiting patients is recorded that suggest a higher sensitivity towards the quality of service in comparison to the cost of service provided. • Patients are found to be satisfied with certain elements such as hygiene, cleanliness, staff attitude etc. When interviewed, the patients are found to demonstrate a high will to remain associated with the clinic.

TABLE 5.1: CHAPTER 5 FINDINGS (SUMMARY)

CHAPTER 6 - DISCUSSION

6.1 INTRODUCTION

The majority of health service provision in Pakistan is in the private sector; therefore, it is necessary to consider the market forces that influence customer (i.e., patient) perceptions of value, service exchange, and choice of the service provider. However, to understand the perceptual dynamics in terms of choice and value, it is necessary to contextualize the findings within the healthcare sector since the recipients of the service exchange cycle are patients rather than consumers per se, and this has significant implications for value perceptions. Having contextualized the findings within these two relevant domains, it is then possible to discuss the nature of how value is determined within the two case study settings (Clinics A and B) with respect to three elements of value: financial, perceptual, and technical. The findings are also discussed within the context of developing countries (of which Pakistan is a prime example). This context has important implications in terms of location and, therefore, the institutional arrangements in which the two case study clinics operate. At this point, it is appropriate to discuss the findings within the context of the SDL conceptual framework presented in Chapter 2. The findings indicate nuances, not present in the extant literature with regard to service exchange dynamics. The chapter ends with a discussion of the implications for SDL theory.

6.2 CUSTOMER SEGMENTATION: A CORE MARKET DYNAMIC

The literature review arrived out from this research revealed an apparent lack of empirical evidence with regards to customer segmentation. The work of Vargo and Lusch (2004; 2008; 2015; 2016) though has contributed towards understanding the role of SDL and value cocreation when it comes to services in general, however, they appear to oversimplify/overlook the overall fundamental structure of the healthcare sector, demonstrating a weak empirical grounding in this regard. Research by Joiner

and Lusch (2016) focused entirely on SDL's role in healthcare yet it failed to determine/discuss the different markets of healthcare or to provide any empirical evidence regarding the applicability of SDL in the developing world. Another example is from the study of Vespestad and Clancy (2018), who attempted to address the role of SDL in primary care services, yet no information was observed that could shed light on the presence of different market segments in healthcare. Lastly, the study by Osei-Frimpong et. al. (2018) was observed to examine patient cocreation activities in healthcare, but that too was seen to lack in addressing the trends in different market dynamics. To overcome this discrepancy, the author has orchestrated this study in a way, in which the empirical evidence gathered from the case studies is used to verify if the research findings are consistent with the SDL theory (Vargo and Lusch, 2004). The focus of this section is to understand if the special characteristics of the healthcare sector resonate with the theory on SDL based on the empirical evidence.

Because the unit of analysis for this study is private healthcare clinics in Pakistan, and the private sector represents the main means of service provision in the developing countries, it makes sense to consider how private healthcare, particularly in the case of Clinic-A and B operates in a market environment. As aforementioned, there appears to be a limited discussion of market segmentation within the literature of SDL theory. This is surprising considering SDL is primarily concerned with the provision of service marketing. It is so the theory of SDL is presented by the authors, especially Vargo and Lusch (2004), as a one-size-fits-all framework. This sector looks at market segments served by Clinic-A and Clinic-B.

Pakistan is reported to have a clear dominance of the private healthcare sector, providing services to 71% of the resident population (WHO, 2020). The rural/urban distribution of human resources for health in Pakistan provides another challenge where 14.5 physicians are available for a 10,000-population density in urban areas and 3.6 GPs provide services for the 10,000-population density in the rural settings (Key-Informant, 2019; WHO, 2020). Lifestyle, socio-economic settings, education, and culture play a vital role in shaping up the demand of healthcare markets in Pakistan (Shaikh et al., 2017). Being a developing country, economic indicators show huge differences in development between the rural and urban areas of Pakistan, and the same is observed in low/high socio-economic societies scattered in the country (HSPR, 2018; Shaikh, 2015). All these factors lead to a scenario where market

segmentation becomes a necessity for service providers to meet the demands of the customers (patients), who exhibit different needs when it comes to seeking medical attention. Service providers, being aware of these requirements, shape up their service delivery structure to accommodate their target audience. Findings from Clinic-A and Clinic-B are used to determine why customer segmentation is a core market dynamic in the developing world.

Understanding customer segmentation in the healthcare sector is considered vital to this study. The reason behind its significance is based on the findings of healthcare clinics (Clinic-A and Clinic-B) that portrayed an entirely different service delivery mechanism as opposed to the studied literature, that focused on healthcare setups in the developed world. Implications drawn towards enhancing SDL theory in the developing states require an in-depth assessment of all the elements that shape up a specific service delivery mechanism, as seen in the studied clinics. The first and foremost aspect in this regard is believed to be the focus on **operand** and **operant** resources. As demarcated earlier in the literature chapter, operand resources are essentially tangible and generally located at the passive position in production activity. Operant resources, however, are essentially intangible, continuous, and dynamic, and generally located at an active position in a production activity (Vargo and Lusch, 2004).

Before deliberating on the segmentation observed in Clinic-A and B, the researcher deems it important to summarize the differences recorded in both settings. Clinic-A was observed to be located in a geographical area that can be characterized as a low-socio-economic society. The majority of the interviewed patients were found to belong in a middle-income earning group and were seen to be strongly driven by the social constructs existing in their society. Alternatively, Clinic-B was found to be located in a posh society of Pakistan (providing services in the country's capital). The majority of the patients visiting this clinic were found to belong to an upper or elite class of the society. Adherence to social norms was observed to be weaker amongst the service beneficiaries with utmost focus relying on the quality-of-service exchange. Having summarized the differences in both market segments, the researcher will now attempt to discuss the segmentation between both clinics under the elements of resource allocation (operand and operant centricity).

6.2.1 OPERAND-CENTRIC SEGMENTATION (CLINIC-A)

To provide services to cost-sensitive customers, Clinic-A is observed to have adapted to a mutually beneficial strategy. In essence, the strategic driver is providing services that can be delivered in a cost-effective way i.e., a standardized approach of service provision. This approach is believed to be more 'operand' than 'operant' in nature. Moreover, this strategy is quite famous in developing countries and the evidence of its existence in the cost-sensitive areas is already discussed by the researcher in the literature chapter (Leatherman et al., 2018; Angeli and Jaiswal, 2016). The operand-centric needs observed in the service beneficiaries of this segment means that the service providers adhere to the customer requirements and shape their service delivery accordingly. If compared to the studies explored in the literature review section, patients from Clinic-A are observed to be more 'passive' in nature, expecting value propositions from the service providers (McColl-Kennedy et al., 2012). Empirical findings from the case studies have also affirmed that an average patient visiting the healthcare clinic prioritizes purchasing medicine/s from Clinic-A, rather than showing consideration for the overall healthcare service exchange. Consequently, understanding the reason for acquired ailments or obtaining knowledge to prevent future diseases is seen to hold negligible importance for these patients. This mindset categorizes the patients to be operand-centric in nature i.e., basing their priorities on tangible commodities (Li et al., 2018). Also, having such a mindset by the service beneficiaries creates an atmosphere where the primary source of a firm's competitive advantage becomes fixated on operand resources. Findings have also affirmed that the healthcare clinics working on a similar model to Clinic-A base their economic exchange on delivering goods to be sold. It is due to this reason that the dispensary operating in Clinic-A is seen to offer cheap unlabeled medication to the visiting patients.

From the service provider's perspective, Clinic-A is seen to target the patients from low socio-economic backgrounds based on its geographical location. As aforementioned in the methodology chapter, Clinic-A is located in a region that is surrounded by a majority of the people belonging to either the low or middle class of society. Therefore, in response to the demand/trend of the market, the service providers are seen to offer simple services that are reductively oriented and focused

on cost-minimization. Findings from Clinic-A affirmed that the presence of reductive service orientation, operand-centric resources, and low top management commitment has no impact on the profitability of such business models. This is in essence a GDL segmentation strategy aimed at keeping costs low. Moreover, this GDL approach is seen to benefit Clinic-A as a business entity, because it satisfies the demand characteristics of this market segment. These factors are seen to give birth to a market that operates on the needs of service beneficiaries and is driven by the operand-centric institutional arrangements that both the service providers and service beneficiaries have to abide with.

6.2.2 OPERANT-CENTRIC SEGMENTATION (CLINIC-B)

In contrast to Clinic-A, Clinic-B is seen to provide quality services to its patients in terms of offering individualized service, a simple patient registration system, post-clinical services, and comfortable seating arrangement, etc. This service delivery mechanism is designed to cater to the needs of patients, who are less sensitive to the costs of treatments and their lifestyle choices increase the expectations of the treatment they expect from healthcare clinics. In simple terms, the patients visiting Clinic-B are regarded as 'more demanding customers' for whom the needs of the market are seen to differ immensely as compared to patients associated with Clinic-A. Findings from this research suggest that the patients of Clinic-B expect a greater amount of knowledge transfer to/and from the service provider. In multiple instances, these customers have been found to engage in activities that can be regarded as an 'active participation' towards relational exchanges and coproduction. The operant-centric needs of these patients ensure reciprocal arrangements by the service providers who allow these customers to engage in the service design and the production activity. Under such circumstances, having operant-centric resources and an accommodative service orientation becomes a necessity for service providers to have a successful business model. If examined under the already discussed theory on SDL, strong innovation and patient involvement in the service design becomes aligned to patient expectations, and hence, mutual value creation is observed in the SDL presence framework of healthcare.

It is due to the above-mentioned characteristics that the customers of Clinic-B are observed to be segmented into a different market group. Operant centricity of the service beneficiaries means that the value is determined based on 'value in use'. These findings reveal that SDL theory only aligns with the business models that target high socio-economic societies in the developing countries or when healthcare is free (as is seen in most of the developed world). The institutional arrangements observed in this scenario are seen to be the reason why there is a need/existence for a separate market in the high socio-economic areas of developing countries. Service providers (like Clinic-B) are the examples (and empirical evidence) of different healthcare markets operating in the developing world.

By analyzing the empirical evidence acquired from the case studies, it appears that Vargo and Lusch (2004,2016) have oversimplified the nature of service provision in the healthcare sector. This has led the researchers to base their theories on generalizations that ignore different market dynamics in the healthcare sector operating all over the globe. The author's observations of major differences in Clinic-A and Clinic-B have helped to clarify that customer segmentation is a norm (or necessity) in the healthcare sector of developing countries. As explained above, Clinic-A and Clinic-B show huge differences to one another in terms of the markets they cater to. Customer segmentation is considered a core market dynamic in the developing world and the needs of customers vary according to numerous factors that have been highlighted above. Under such conditions, scrutinizing the two clinics under a generic healthcare model would lead to inaccurate findings that can be far from empirical grounds. Moreover, reality begins to surface at this point, where considering Clinic-A and Clinic-B competitors to one another would not hold sense. This is based on the fact that the clinics serve different target audiences, and the market needs are recorded to be far more different for the clinics to be seen as competing businesses.

All of these findings suggest that market segmentation is not only economic but is also based on perceptional dynamics. This understanding now allows us to examine the concept of a different market for patients, as compared to the traditional business consumers, that is already discussed in Table 2.4 of the literature review chapter.

6.2.3 INSIGHT INTO THE B2P MARKET

Exploring the extant literature along with the investigation of both healthcare clinics has pinpointed certain market dynamics of the healthcare market. Recollecting previously mentioned information, a niche market for patients was identified in **Table 2.5** of the Literature review section that highlighted 4 major differences between conventional business consumers and the customers of healthcare (Patients). A need or acknowledgement for a separate market for patients was deliberated in the literature section that was based on the analysis of various examined literature sources. The author designed **Table 2.6**, which identified and classified each element of Table 2.5 with the relevant academic sources for evidence. A pattern was seen to emerge from comparing and contrasting the studied literature that helped the author to realize 4 components of Table 2.5, which were seen to be responsible for the creation of a separate market for patients. The newly identified market i.e., **B2P Market** was seen to differentiate patients from conventional business consumers based on service perceptions, psychological orientation, availability of services, and choice of selecting or rejecting a service. The 4 components of **Table 2.5**, as seen in the literature section, were highlighted as:

1. **Psychological Orientation**
2. **Will**
3. **Options and**
4. **Baseline**

As the framework for the newly identified market **(B2P)** has been laid by the researcher (in the literature review section), the next reasonable approach was to validate these findings from the two explored healthcare clinics in this study. The author tested this model (Table 2.5) in both clinics to verify the practicality of the B2P market in the empirical settings. Researching the need and existence of a separate market for patients is made paramount for this study as value creation is observed to be a mutual process (dyad) and consequently, the required value propositions are only possible to be effective when a specific target audience is identified. Furthermore, every market is seen to have different needs which are addressed by the service providers; hence,

it becomes necessary to identify what market category the recipients of service belong to. This 'identification' helps in creating better value propositions for the service beneficiaries and elevates the chances of attaining mutual value creation. Also, various academic scholars have been reported to argue that healthcare, with time, has developed into a service business (Gray, 1983; Mankiw, 2017; Gandolf, 2020). Based on this understanding, the researcher compared 2 private healthcare practices in Pakistan to establish if the same could be deduced for healthcare in developing countries.

Moving forward, the findings from Clinic-A and Clinic-B are presented under each component of Table 2.5 to analyze the practicality of this model in the empirical settings:

PSYCHOLOGICAL ORIENTATION

The first component of Table 2.5 and 2.6 deliberates on the differences between conventional business customers and patients based on their psychological orientations. The author aimed to authenticate if the academic sources justify 'anxiety orientation' for the patients in the empirical settings. Exploring Clinic-A and Clinic-B revealed that all the interviewed patients were suffering from anxiety (in one way or another) and were found to expect the element of 'care' and individual attention from the healthcare providers. The cause for patient anxiety was seen to associate with the illnesses, diseases, etc., they came to rectify in the clinics. Further analysis of patient psychological orientation revealed that the purchase of service/s by patients was directed towards reduction of anxiety/suffering rather than bringing the element of joy or happiness, leading to service purchases. Referring to the findings of Clinic-A, the CEO is reported to have emphasized building relationships with the patients on an individual level, keeping in mind their needs, when the patients are experiencing anxiety due to their respective ailment/s. Similarly, the patients of Clinic-B were found to be given priority treatment by the clinic employees, keeping their psychological state (anxiety) and need for 'care' in mind.

This special need for 'care' is seen to apply only to the customers of healthcare and can be seen as an element that differentiates patients from conventional business consumers. According to the studied literature, conventional business customers

portray 'excitement orientation' that leads to the purchase of services (Belk, 1992; Hebdige, 1979), rather than basing the decisions which are viewed through a negative lens. The findings from both healthcare clinics, hence, are seen to affirm the presence of 'anxiety orientation' in customers of healthcare and advocate for a special market, that is different from conventional business customers.

WILL

Both case studies affirmed that patients purchase healthcare services because of their 'tethered will', as explained in the model (Table 2.5). As not getting better is not a choice for patients, they cannot exhibit the characteristics of B2C customers, who can choose between different options and enjoy the option of free will to either purchase or neglect a service without facing serious health-related consequences. A strong relevance with literature, in this regard, is observed in Clinic-A where patients (in the majority) are seen to belong to a low- or middle-income group, still making purchases of healthcare services due to their 'tethered will'. A similar observation is noticed in Clinic-B where patients demonstrated the will to purchase quality services (offered for higher prices) to receive the treatment for their respective ailments. Again, the option of 'not getting better' is seen to not fit in this scenario and an understanding is seen to develop, which disassociates patients from the B2C customers based on the will to purchase service.

OPTIONS

The element of limited and unlimited options is also confirmed from the explorations of both case studies, especially after interviewing patients visiting for medical emergency reasons. The two important factors, limiting the options for patients, either included being restricted to local GP or lacking time to make decisions. In the case of Clinic-A, the majority of the emergent patients visited the clinic based on shortage of time and finding the surgery their nearest possible option for treatment. However, in the case of Clinic-B, patients were recorded to provide multiple reasons for visiting this healthcare clinic as their (limited) medical emergency option. The motives presented by these patients range from, ease of travel to the clinic through the company's

ambulance service, shortage of time to make decisions, and being limited to the GP (with all their health record history limited to the clinic). This finding is also seen to distinguish patients from conventional business customers who have the options to choose amongst many competitors. According to the studied literature, business customers have more access to information and time to help them compare between different competitors.

BASELINE

The psychological viewpoint taken from the model (Table 2.4), yields the same findings based on the fact that patients from both of the clinics visit the service providers for trying to achieve the previous psychological state they exhibited (before the ailment). Interviewed patients of Clinic-A and Clinic-B were recorded to purchase the healthcare services to return to the baseline and feel healthy again. Business consumers in this regard have been argued to make service purchases for attaining a new psychological state, rather than returning to the old one (Elg et al., 2013). The aim for business customers is not to return to the baseline (unlike customers of healthcare), or in other words, achieve a previous state of mind.

Findings from the studied literature led to an understanding where the market for patients was found to fall under the category i.e., B2P with significant differences to the conventional business customer market (B2C). Explored case studies helped the researcher to understand this phenomenon on a deeper level, where cocreation of value was found to be higher with the patients who were treated according to the needs, specified of a B2P market customer. An example of this concept is understood from the findings of Clinic-B where direct and indirect approaches of relationship management (RM) are practiced for building trust and enhance individualized relationships with the patients. The aim of RM is focused on patient experience and in-depth awareness of their individual needs. The crux of these findings can also be understood from the SDL perspective (Vargo and Lusch, 2004), where the potential of patients (actors) to actively engage in value cocreation can be only realized when they are treated according to the requirements of their specific market group. It is thus concluded that value cocreation in healthcare setups is highly dependent on the

service delivery based on the understanding of B2P market needs. Also, the results affirmed the consistency with available literature as both of the clinics were found to fall under the category of a healthcare service business (B2P), providing healthcare services for the exchange of operand resources (money). This understanding helps in establishing research accuracy at one end and strengthens the concept of available literature on the other.

Discussion of the above-mentioned findings has pinpointed certain elements that are believed to be missing in the SDL theory. The first important element being, 'market segmentation', which is not only overlooked in the SDL theory by Vargo and Lusch (2004, 2008, 2015) but is also missing in the studied literature that focuses on SDL in healthcare (Osei-Frimpong et al., 2018; Hardyman et al., 2015; Nyende, 2018). Secondly, the factor of 'customer expectations', which is related to how the healthcare market in developing countries is segmented, is also seen to be missing in the studied literature. Exploring both clinics has revealed that **value** plays the most important role in determining how the overall sector of healthcare in developing countries operates. Therefore, to understand the exact role, the author is now going to discuss all three components of value for both healthcare clinics respectively.

6.3 DETERMINATION OF VALUE IN CLINIC-A

6.3.1 FINANCIAL VALUE IN CLINIC-A

An important finding that developed from studying Clinic-A is the emergence of simple, low-cost, and functional products or services, in response to the needs of more resource-constrained healthcare consumers. Financial value for the patients living in middle-or-lower-income groups is seen to subdue the elements of technical and perceptional value. As observed in previously studied literature, the cost of medical treatments and the risk of catastrophic healthcare expenses plays an important role in how these patients perceive value (Angeli and Jaiswal, 2016). An important reminder at this point is the general trend of developing countries, where patients are keen to obtain private healthcare services by paying from their own pockets. Health insurances

are rarely offered or purchased by the general population in developing countries (Khursheed et al., 2015). In such instances, the patients of the studied clinic were found to disassociate themselves from the technical value the clinic had to offer. Patients of Clinic-A were found to mostly belong in the middle- or lower-income groups and hence were observed to be more sensitive towards financial costs attached to obtaining the healthcare services. It is safe to say that the quality of services for these patients is seen to have very little impact on future buying behavior. The technical components such as waiting time in the clinic, cleanliness, staff behavior, etc. demonstrated negligible difference to the patients in Clinic-A in terms of changing their service provider. This is attributed to the reason that affordability for these patients holds maximum value and lower cocreation between the actors does not yield the same results as seen from the findings of studied literature in the developed countries.

On the provider's side, delivering healthcare services in the low socio-economic areas is seen to come with challenges which include, infrastructural voids and affordability, due to maintaining a lower fee for consultations. The financial value for these clinics is observed to be associated with achieving a higher volume of customer base and adopting strategies such as cost penetration of the market. As Clinic-A is a small business setup (SME), value for the clinic's management is seen to rest in gaining the highest possible 'returns on investments' (ROI) with the lowest possible cost inputs. Clinic-A and similar setups are seen to capture strategic advantage over substitute clinics by offering 'low-cost services' to the patients and proposing value based on marketing themselves as 'affordable service providing institutions.' In this particular scenario, 'market intelligence' is observed to be a very important factor for the stakeholders as they are seen to seek strategic advantage by offering competitive prices to the patients as compared to the other clinics. Knowing the cost of treatment offered by nearby healthcare clinics is important for the stakeholders to adjust their service pricing and attract more customers of healthcare. Similar to the service beneficiaries, the providers of healthcare services are seen to base most of their focus on financial value. As the provision of complex, individualized delivery comes with additional costs, the clinics tend to maintain a simpler service structure and limited customization elasticity.

Determining the financial value in a lower socio-economic healthcare clinic (Clinic-A) has pointed out many differences to the developed world. An example can be taken

from the management of Clinic-A, which offers a mix of operand and operant resources (mainly operand) to the patients in exchange for acquiring operand resources (money). Patients, on the other hand, are recorded to be content with these offerings due to financial and cultural factors as explained above. To minimize costs, the management of Clinic-A offers standardized services to the patients. These services, though demonstrate operand-centric offerings, but are seen to be accepted by the majority of the patients due to the financial costs attached to the more costly alternative of 'quality healthcare'.

Evidence gathered from Clinic-A denotes that sharing of knowledge is negligible between the service provider and beneficiaries. Moreover, services are simpler, standardized, with lesser learning for improvement in capabilities for the organizations. This overall scenario shapes up the organizational culture of the clinics, which are dominant in lower-income groups as highlighted by various studies on the Pakistani healthcare sector (Akram and Khan, 2007; Khursheed et al., 2015; Anwar et al., 2012). With all the factors pointing towards operand centricity and lower presence of SDL in the healthcare clinic, the service business is still found to be making profits and capturing higher market presence with time. These findings suggest that existing literature on SDL does not match with the empirical evidence gathered from the case study. Cultural norms, financial factors, and other related elements need to be studied in more depth for the developing countries, to have a clearer understanding of SDL and its applicability in such settings.

6.3.2 PERCEPTIONAL VALUE IN CLINIC-A

Observations from Clinic-A depicted a scenario where value perceptions of the patients (in general) are seen to be based on lower expectations, especially in terms of service quality. In this situation, the element of financial value is recorded by the author to directly influence the perceptional value of service actors. Patients in this clinic are found to exhibit lower expectations in terms of service quality when observed against a consolidated set of expected services spanning across the clinic's service portfolio. This observation can also be understood from the factors arising due to

organizational size and underlying business requirements. An interesting finding in this regard can be understood from the interview results of Clinic-A patients where 0% of the respondents showed complete satisfaction with the service delivery, yet they wanted to retain their association with the clinic. This finding is important as it validates the low importance of service delivery and the quality of services to the patients, in terms of associating or maintaining relations with a healthcare clinic. Discussing the lower-income socioeconomic settings, the foremost finding suggests institutional isolation and idiosyncratic beliefs being prevalent in these societies. Various studies have tried to capture this concept under the light of institutional theory lens and all of them agree on the basis that lower-income-patient settings are different from the higher tier markets (London, 2009; Rivera-Santos et al., 2012). An example in this regard is taken from the responses of the patients of Clinic-A, who have been reported to state the reasons for acquiring services in this clinic as majorly based on social recommendations.

Another finding that is found to be consistent with the studied literature argues that informal institutions demonstrate a dominant role in governing social life in these contexts as opposed to formal ones (Rivera-Santos and Rufín, 2010). This shows that there is an institutional rift that exists between high-tier markets and the low-tier ones. This institutional divide is seen to manifest into different meanings and values attached to the services, hence impacting the perceptional values of service actors. 'Social influence' is one of the major factors that explain the 'operand-centric service expectations' mindset of the patients in the middle- or lower-income societies of Pakistan. A related factor is 'cultural influence', which is found to be dominant in these societies, as also highlighted in the article by Angeli and Jaiswal (2016), in the literature review section. Middle- and lower-income group patients are observed to show keen adherence to social norms, for example, same-gender practitioner preference for consultation, etc. The management of Clinic-A is also seen to regard social norms to attract the patients adhering to social standards and is seen to offer services like; Lady doctor's services for female patients and patient seating based on segregation between males and females.

As Clinic-A is based in a lower-income society, high information asymmetry is also observed between the patients and service providers. The reason for this asymmetry is attributed to the low degree of education and health literacy of the population, again

influencing the component of perceptional value. From the service beneficiary's perspective, institutional isolation is seen to be resulting from the mix of lower education, financial constraints, inability to identify ailments, and heavy reliance on local communities and social networks to determine their health conditions. Under these influences, the perceptional value of patients is seen to lie more towards adhering to social norms rather than the quality of services they receive. This finding is evident in Clinic-A where the presence of a female doctor and segregation of seats for male and female patients is prioritized to satisfy the informal institutional arrangements. In such cases, the actual delivery of service is seen to be ignored by the patients as they find perceived value to be highly embedded in the social norms and culture. From the service provider's standpoint, the perceptional value is seen to be driven by the social constructs and collective institutional arrangements that involve multiple actors (Vargo and Lusch, 2015). This is based on the collective mindset of patients, providers, suppliers, who are seen to collectively influence how the perception of value is to be formulated. To understand this analysis, multiple findings from Clinic-A can be observed respectively. The first example, as already mentioned above, is the strong social influence towards adhering to the social norms. Under such circumstances, the service provider (CEO) is seen to have 'no option' but to observe and obey the collective beliefs of the society. Not adhering to these constructs can have a negative impact on the service institution (Angeli and Jaiswal, 2016) that may result in financial loss or even bankruptcy. Strong social and cultural influences are observed to surpass the value patients perceive from the actual service quality in Clinic-A. In simple words, the female patients belonging to these socio-economic settings would reject better service quality/delivery from a male doctor and would prefer a female doctor for consultation, even if the quality of service is noticeably inferior. An interview response from the female patient is presented below:

"*I will not accept consultation with a male doctor even if he is the most reputed doctor in town. For us women, the priority should be based on consulting with female doctors for any healthcare needs*"

Another example in this regard is taken from the collective beliefs of the lower-and-middle income societies where the concept of 'Doctor knows the best' mindset is widely followed (Angeli and Jaiswal. 2016; Shaikh, 2015). This perception is linked to lower education of visiting patients along with lesser knowledge of ailments they visit

the clinic for. This overall institutional arrangement gives birth to lower knowledge sharing between the service provider and beneficiaries. Patients are found to be keener on acquiring medication for the ailment they visit the clinic for, rather than inquiring more from the practitioner to prevent similar problems in the future. The consequential impact on the service providers (as noticed in Clinic-A) leads towards formulating a service delivery mechanism where the general practitioners keep the sharing of knowledge to the bare minimum and focus more on prescribing medication. Although this phenomenon goes against the basic understanding of SDL and value cocreation (Storey and Larbig, 2017; Anderson and Ostrom, 2015), the practice is seen to be ‘expected’ between the service actors. Therefore, an understanding develops that developing countries do not follow the literature of SDL in its complete essence and value is subjective for different audiences.

6.3.3 TECHNICAL VALUE IN CLINIC-A

As aforementioned, technical value in healthcare setups relates to the efficiency and effectiveness of the services provided/received. This component of value is studied separately for service providers and service beneficiaries in Clinic-A and is seen to represent the conditions of healthcare clinics based in the lower socio-economic settings.

From the service provider's perspective, higher technical value is recorded when the clinic demonstrates efficiency and effectiveness on the operational activities. Expanding on this understanding, efficiency for the clinic is determined by recording; throughput times of consulted patients, the effort required to perform the processes, and the capacity of processes to perform at stated performance parameters. Effectiveness, on the other hand, is recorded by observing the extent to which value proposition is attained according to the set service exchange objectives. Doing so also requires the need to record the 'utility of operant resources', which is kept into consideration by the researcher to acquire clearer findings. Henceforth, the first finding in this regard is associated with the stated performance parameters set by the top management of Clinic-A. It is noted that due to the high influence of financial and

perceptional elements of value on the institutional arrangements, the top management of Clinic-A has chosen to set lower performance parameters as compared to the high-end medical clinics. Even with the lower parameters, the clinic is observed to fail in achieving the full capacity of expected performance on numerous occasions. The clinic is found to fail in achieving technical value on the operational processes and therefore, the impacts are visible from the longer patient throughput times, mismanagement in rush hours, and prescription errors that have been identified by the researcher. The effort required for the operations to run smoothly is found to lie in the mix of operand and operant resources. For example, in the case of Clinic-A, having more operand resources (staff) and more operant resources (IT systems) is expected to aid in improving patient management and experience. However, the financial constraints prohibit the clinic to achieve its full potential and consequently, lead towards an inefficient exchange of competencies. Therefore, the clinic is found to be ineffective in creating operative value propositions for the visiting patients. Lower utilization of operant and operand resources is recorded to be the main reason for lower technical value findings. An important understanding from the results is thus seen which advocates for the presence of 'dynamic capabilities' (Teece, 2018) in developing countries to yield a high-value cocreation between the actors, instead of completely focusing on the operant resources (Vargo and Lusch, 2004). Focusing merely on the operant-centric approaches in Clinic-A might lead to improvement in certain service delivery operations but the handling of a high influx of patients is only seen to be possible with a higher operand resource orientation (employees). This is an important finding as it challenges the very basic notion of service dominant logic in healthcare settings and thus, will be discussed in detail in the upcoming sections.

Moving on to the service beneficiary's perspective, technical value is seen to lie in, receiving an effective and efficient service delivery from the service providers. In this case, efficient delivery means; getting a consultation with the practitioner with low waiting times, and effectiveness is based on how useful the visit to the medical clinic is, in terms of curing ailment/s. From the acquired findings, low technical value is observed for the majority of the patients visiting Clinic-A. 55% of the interviewed patients showed dissatisfaction towards the waiting time in Clinic-A and with minors (children) being most impacted by the long delays. Alternatively, effectiveness is recorded to be high as most of the interviewed patients claimed to be associated with

the clinic for a long duration due to effective medical results. Although it is learnt that the patients of Clinic-A focus most on the 'lower cost of treatment' aspect, the researcher found 'remedy effectiveness' to be another reason for the patients to remain associated with the clinic. Concluding from both aspects of the technical value for Clinic-A's patients, it can be deduced that the evidence of value creation is present between both the service actors. Although MVC is not found to be impeccably high, it is still present in a major aspect of service delivery. This finding also suggests that the patients in Clinic-A demonstrate 'interpretation of value' differently from the ones present in developed countries. Moreover, the service exchange objectives set by the patients show the influence of financial value on their decision-making, and thus, the expectations are found to be lower concerning the technical value offered by the clinic.

The overall understanding of the technical value in the lower socio-economic settings demonstrates a service design that is focused on the principles of service reduction and standardization of services. Service providers and service beneficiaries show low motivation for creating service propositions that target the technical aspects. As value is found to be subjective for both the service actors in lower socio-economic settings, mutual value creation is recorded to get highly impacted from the financial rudiments. Interestingly, this finding does not justify the literature on SDL, which focuses on the high involvement of patients in the service design, high use of operant resources, and accommodative service orientation to be the fundamentals for achieving a high MVC (Yan and Kung, 2018). Further explanation of this finding in the upcoming sections will justify how the developing countries differ in terms of value creation from the developed states.

6.4 DETERMINATION OF VALUE IN CLINIC-B

6.4.1 FINANCIAL VALUE IN CLINIC-B

The difference of value perceptions in socio-economic societies of developing countries has been deliberated upon by the researcher in the previous sections. Moreover, the findings from Clinic-A have demonstrated that lower-and-middle-income societies show high sensitivity towards the cost of treatments. This section will

discuss the findings from Clinic-B and will elaborate on how financial value is interpreted in the high-income societies of developing countries.

An important finding that developed from studying Clinic-B is the emergence of high-cost, complex and functional services that are designed in response to the needs of resource-abundant healthcare consumers. In contrast to the patients of Clinic-A, consumers in this setting are found to 'expect' the technical and perceptional components of value to compliment the higher cost of treatment, as opposed to the clinics serving lower-and-middle income groups. Therefore, the presence of such high-end clinics is seen to be strategically located in the high-income earning societies of the developing countries. The same trend of 'paying from pocket' applies to the consumers of healthcare in the high-end clinics but due to their respective socio-economic group/s, such patients are found to be less sensitive towards the higher treatment costs when it comes to choosing the healthcare provider/s. It is also found that the focus of patients who are associated with clinics (like Clinic-B) lies more on service delivery, quality, and social influence, rather than the financial factors. This is evident from the exploration of Clinic-B where the quality of services is found to have a major impact on the future buying behavior of the associated patients.

From the service provider's perspective, financial value is recorded to lie in skimming the market and by offering quality services against higher costs for treatment. The main difference observed between the two case studies is based on the fact that Clinic-B thrives to gain a strategic advantage by offering superior services against its competitors. The impact of the cost of treatment is recorded to be quite low with the visiting patients of this clinic, as compared to Clinic-A. The management of Clinic-B is found to acquire expensive resources (operand and operant) to gain a strategic advantage. In contrast to Clinic-A, the management of this clinic is seen to focus on the 'lower-volume-high-cost' strategy. Clinic-B aims to retain the existing patients and focus on skimming the market. This strategy enables the organization to gain significant ROI to keep the business profitable. The long-term relationship with the patients helps the clinic in gaining revenue for the necessary expenses. For example, the clinic uses the revenue in purchasing/upgrading its machinery, which falls under the category of operand resources. Alternatively, the management of Clinic-B utilizes this revenue for the operant-centric expenses which include, cost of training employees, etc. The exploration of literature focusing on the higher-end clinics in the

developing countries also complements this finding and discusses the strategies that these clinics adopt to retain the customers. One of the main findings in this regard is the service quality and the VIP treatment, which attracts patients who are less sensitive towards financial expenses. An example in this regard is the provision of VIP rooms which are offered to the surgery patients of Clinic-B at a very high cost.

Determining the financial value in higher socio-economic healthcare clinics, Clinic-B is seen to point out some similarities to the developed states. It is observed that the focus of these clinics is based on delivering quality services and due to the operant-centric management practice, the clinics succeed in cocreating financial value with the incoming patients. An understanding in this regard is the overall service structure of such clinics (Clinic-B), where the expectations of patients and the involvement in service design led to shaping up the operant-centric organizational culture. The findings from Clinic-B show resemblance to the concept of SDL and suggest that value is therefore subjective to the recipient audience. A deeper understanding of the socio-economic differences, sensitivity towards the cost, and institutional arrangements are necessary to understand the applicability of SDL in the healthcare settings of developing countries.

6.4.2 PERCEPTIONAL VALUE IN CLINIC-B

Value creation with the patients of Clinic-B manifests a trend development different from Clinic-A. The biggest difference recorded by the author is the value perceptions of the patients that demonstrate very high expectations from the institution. Patients in Clinic-B are seen to expect a service quality, specially tendered for their individualistic needs. The different managerial mindset of this clinic also reciprocates patient expectations by putting efforts in relation-building and retaining the customers of healthcare. Unlike Clinic-A, management of this clinic is found to value patient feedback and opinions. Value for Clinic-B lies in skimming the market through the factors that include, top management commitment, operant centricity, and accommodative service offerings. Similarly, value for the patients of this clinic lies in receiving intangible gains that can provide them with trust, emotional satisfaction,

accessibility, quality of life, and other assurances (Zhang et al., 2015). An important aspect in this context is sharing of knowledge, which is repeatedly emphasized in literature focusing on SDL and cocreation of value (Vespestad and Clancy, 2019; Yan and Kung, 2018). The author has elaborated in the literature section how knowledge has been categorized as an operant resource, hence an organizational culture maintaining knowledge as 'organizational value' infers that the emphasis resides in achieving high operant value. As most of the patients in Clinic-B are found to belong to upper or elite social classes, their knowledge of a healthy lifestyle helps them in realizing the high benefits of receiving operant value. For this purpose, these patients are found to have the will for spending large sums of operand resources (money) in exchange for receiving operant resources. An important clarification for this finding links with the literature that acquiring operant value is not a short-term process, yet the value once received is impeccably embedded within Clinic-B patients, who demonstrate the will to associate with the firm generating continuous future value for them. This behavioral tendency is the output of focus on knowledge sharing by overall organizational culture.

Furthermore, value for the management of Clinic-B lies in offering operant resources in exchange for operand resources (money). The main reason for this value perception is based on the phenomenon that the offered operant resources come at a cost to Clinic-B, for example, hiring skilled staff, technological advances for knowledge sharing, etc. Hence, the management focuses on further advancement in the value offerings by the exchange of operand resources (provided by service beneficiaries). This exchange leads to mutual value creation where the service provider and service beneficiary exchange resources to generate value for each other. Patients of Clinic-A are observed to be less sensitive towards the cost of treatment and seen to focus more on the aspect of technical value. This tendency is associated with the geographical location of the clinic, which is based in the upper social level society of Pakistan's capital. Alternatively, value for the patients of Clinic-B lies in receiving customized services with each individual's needs catered to by the clinic's management. Moreover, sharing of knowledge is recorded high in this clinic, services are complex with an aptitude of organizational culture showing positive indication for learning and improvement in the service offerings. MVC is also recorded high due to multiple factors including the exchange of skills, knowledge, information, and resources. Another

important factor observed is the high control from clients in service delivery preferences and the communication effort by the clinic to address those needs. Patients are seen to actively take part in designing services and demonstrating high engagement leading to mutual value creation. These findings exhibit that the existing literature on SDL does match with the empirical evidence gathered from this market segment.

It is necessary to examine all the elements of the SDL presence framework in healthcare to understand these findings in depth. Therefore, the researcher will address those elements after deliberating on the specific market for the healthcare customers, as they are interdependent on one another.

6.4.3 TECHNICAL VALUE IN CLINIC-B

The technical value for service providers and beneficiaries in Clinic-B is recorded by the author from using the same limitations as used for Clinic-A. From the service provider's perspective, it is observed that Clinic-B has chosen to set high-performance parameters to maintain a strong strategic advantage against its competitors. The clinic is found to be running its operations efficiently and achieving the full capacity of expected performance on various occasions. Moreover, the researcher found Clinic-B to succeed in achieving its technical value for the operational processes, and consequently, overall good management inside the clinic has been monitored. Efficiency for Clinic-B is calculated by monitoring the throughput times of consulted patients, the effort required to perform this process, and by evaluating the processes to perform at the stated performance parameters. It has been found that the patients spend less time waiting for their consultation due to the services like pre-registration and online appointment systems. The adequate number of hired staff helps in maintaining the patient throughput times low along with effective training to handle any rush hours incidences. The effort required to keep the throughput times low has been successfully managed due to the 'training' and 'skill development' programs organized by the HR department. Strong top management commitment has been observed regarding the overall operational capacity of Clinic-B and is reflected in the smooth

running of day-to-day operations. Moving on to the effectiveness, it has been observed that value proposition are being attained significantly by Clinic-B, as can be seen from the responses of the patients in the conducted interviews. According to the gathered responses, a total of 17% of interviewed patients had to wait for a long time on one or more occasions to be checked by the doctor. This percentage is quite low as compared to one observed in Clinic-A and shows that the majority of the visiting patients value the services when it comes to the throughput time. The utility of operant resources is found to play a huge part in the acquired results as the exploration of this clinic demonstrated the use of various operant-centric approaches in the overall service structure.

It can thus be said that technical value for Clinic-B holds immense importance as it is one of the main components through which the clinic gains its strategic advantage over its competitors. The model on which this business runs is based on achieving a strategic advantage over the other competitors and is only possible when the technical value is proposed and delivered superior to the other service providers.

Moving on to the service beneficiary's perspective, technical value is seen to lie in receiving an efficient and effective service delivery from the service providers. The patients living in high socio-economic areas of the developing countries have been described as the customers 'expecting' quality services in return for spending higher money on treatment. Technical value for such patients is composed of a service delivery that is based on higher expectations and that serves the individualistic needs of every patient. As aforementioned, the majority of the visiting patients have shown satisfaction with the technical value they received from the clinic (in terms of waiting times). Effectiveness, on the other hand, is also recorded to be high as 42% of the interviewed patients showed complete satisfaction and never faced any issue/s in their visits to Clinic-B. Concluding from both aspects of technical value for Clinic-B's patients, it can be deduced that the evidence of value creation is high between both service actors. MVC is recorded to be high due to the high utility of operant and operand resources. In contrast to Clinic-A, the findings from this clinic show harmony with the literature on SDL by Vargo and Lusch (2004), in terms of interpretation of value. The patients of Clinic-B have been found to show similar traits to those present in the developed states as per their value interpretations, based on the actual delivery and quality of services. The only difference in this regard is observed to be the financial

element, which the customers of developing countries have to regard to acquire the healthcare services. The service exchange objectives set by the patients show the negligible influence of financial value on their decision to reject a service provider (based on high cost). Alternatively, the influence of financial value is recorded high where the patients expect a higher quality of services for willingly paying higher costs for treatment. These findings suggest that technical and perceptional components of value hold the highest importance for the patients belonging to upper-or-elite social classes in developing countries.

The overall understanding of the technical value in the upper socio-economic settings demonstrates a service design that is focused on the principles of service accommodation and individualization of services. It is observed that the service providers and service beneficiaries demonstrate high motivation for creating service propositions that target the technical aspects. As technical value is an important factor for both the service actors, patients engage actively in designing the services along with the service providers. High utility of operant resources and an accommodative service orientation lead towards achieving a high MVC between the service actors.

6.5 THE ROLE OF ‘VALUE’ IN DEVELOPING COUNTRIES

As a consequence of Vargo and Lusch’s (2004) apparent one-size-fits-all conceptualization of SDL theory, there is a need to consider the nature of value, not only in the healthcare sector as discussed above but also within the context of the dynamics of developing countries. This section seeks to discuss the nature of value perception within a developing country. This study has revealed a major finding that relates to the role of value in developing countries, based on empirical evidence gathered from both case studies.

The variation observed in the perception of the value of patients in Clinic-A and Clinic-B is seen to drive the market into 2 completely separate segments. This finding is found to challenge the existing theory of SDL that sees value as an 'objective' phenomenon and then builds the concepts of value cocreation and 'service' as the new marketing paradigm. Vargo and Lusch (2004) have deliberated throughout their

article on the significance of value and value-cocreation between the associated actors. 'Service' is therefore presented as a medium through which value is seen to be created, cocreated, proposed, and delivered. The evidence provided by the two actors (Vargo and Lusch, 2004) is observed to mostly focus on the developed countries and consequently, it has failed to describe how value is perceived, proposed, and delivered in the developing states. Under such circumstances, findings from Clinic-A and Clinic-B have found that the 'one-size-fits-all' approach of SDL might not be wholly valid for exploring value creation in developing countries. Though SDL is argued as the 'new need' for the marketing world, the researcher has found unassailable results from the explored case studies that argue for the need to further investigate the trends in developing states to develop an irrefutable marketing theory.

Results of both the case studies are seen to deliberate that the foremost need is based on addressing the role of value in the developing world if SDL is to be seen as an effective theory on empirical grounds. Summary of the findings (Clinic-A and B) argues for 'value' to be seen as subjective, rather than an objective phenomenon. The author of this research has been successful in acquiring empirical evidence from the case studies which advocates that, 'value' is perceived by patients according to the 'associated factors' that give the meaning of value for them. These associated factors, in turn, are seen to link with institutional theory and socio-economic constructs (Scott, 2001; North, 1990), that change the meaning of value perception for the respective service beneficiaries. Under the influence of these associated factors, the overall significance of service and its quality is seen to be viewed subjectively by the patients as well, portraying results that contradict the original theory of SDL.

As the role of value and perception is closely linked to the institutional arrangements (Axiom 5) of SDL, the next viable approach is to investigate if the results from the case studies are salient to the macro and micro context of value cocreation and SDL theory. Therefore, the author is going to discuss the relevant actor-generated institutions and institutional arrangements within a context of a developing country in the next section.

6.6 INSTITUTIONAL ARRANGEMENTS WITHIN THE CONTEXT OFDEVELOPING COUNTRIES (AXIOM 5 OF SDL)

6.6.1 CLINIC-A FINDINGS REGARDING LOW SOCIO-ECONOMIC SETTINGS

The findings from Clinic-A have pointed out that the primary unit of exchange between the service actors lies in the operand resources. The majority of the interviewed patients described their intention to visit the clinic with the main purpose of acquiring 'medicine/s' for their respective ailments. The important point to understand as of this theme is the utmost focus of patients towards acquiring medication (operand) rather than exchanging 'knowledge or skills' (operant) with the service providers. This product-centric mindedness is not limited to the service providers but is also common at the beneficiary's side, as is evident from the above-mentioned finding. The pointed-out behavior links this finding to the institutional theory where 'the rules of the game' are set collectively by the service actors. In the case of Clinic-A (or similar settings), the demand for operand resources is high and as a result, the supply is met by service providers in terms of their operand-centric product offerings. As aforementioned, end products, in this case, are medicines (operand) and the role of goods is considered primary to the role and quality of service delivery by the service actors (dyad). From the mutual understanding of both the service providers and beneficiaries, customers are considered as the recipient of goods or in simple terms, 'an operand resource'. Due to the product-centric culture, healthcare clinics in developing countries are found to excessively take part in the 'forward integration' of their businesses to match the supply with demand. Going into further depth of this finding, a cultural norm is observed where healthcare clinics tend to propose value by providing/dispensing the product, rather than improving the overall service delivery. This forward integration of businesses requires the clinics to establish a dispensary in the premises of the clinic and keep a good stock of operand resources (medicines). However, it becomes necessary for the clinics in low socio-economic settings to keep their resources operand (or be product-focused) or risk losing their patients to the other clinics which market their businesses with the product offering in their value propositions.

As Clinic-A is seen to follow the GDL approach of marketing, the main focus of service providers is seen towards segmenting, penetrating, and distributing to the patients. Alternatively, the institutional arrangements present in the lower socio-economic

settings ensure that the patients expect the same from the service providers. The choice for healthcare service by the patients reflects the mindset where these consumers seek value propositions from the service providers based on their determination of value. The most important factor to consider here is how the value is determined in low socio-economic settings. The findings from Clinic-A have pointed out that value is determined by the producers and is embedded in the operand resources (medications). Previous sections of this research have elaborated on how value is subjective to the recipients and it has been highlighted that the financial component of value serves as a primary factor for patients to choose a healthcare service provider. Service providers (as in the case of Clinic-A) have been found to use the strategies such as, market intelligence to propose the best value to the patients, which in these cases is an operand resource (cost of treatment).

The overall trend that has been observed from the exploration of Clinic-A is that the need for such markets lies heavily on the value propositions based on product offerings. Operant centricity in such settings has a very low impact on consumer behavior and comes with challenges such as high financial input. Moreover, the cultural and social constructs are found to create an atmosphere where marketing the business through operant-centric initiatives comes with numerous challenges and lower ROI. The invisible hand of the market is therefore seen to compel the service actors for the continuity of product-focused offering and a GDL approach of marketing management.

6.6.2 CLINIC-B FINDINGS REGARDING HIGH SOCIO-ECONOMIC SETTINGS

An important finding that has emerged from the exploration of Clinic-B is the high usage of (both) operand and operant resources in the clinic's healthcare delivery settings. This means that Clinic-B uses a mix of resource orientation (operand and operant) to satisfy the demands/expectations of the patients associated with this clinic. From the clinic's perspective, the reason for this resource orientation is based on the fact that Clinic-B operates in a segment that is more competitive than Clinic-A, therefore, the management has to (additionally) focus on the quality-of-service

exchange (operant centricity) to enhance customer retention. From the patient perspective, the customers of Clinic-B are found to be less sensitive to the cost of treatment, more educated, and belonging to a social class that is living with high standards of living. The lifestyle choices of these patients categorize them in a group that is equally focused on the quality of goods (medication) and the superiority of services received.

It is observed that the primary unit of exchange in high socio-economic areas is mostly comprised of knowledge and skills (falling under the category of operant resources). As compared to the theory on SDL by Vargo and Lusch (2004), the service exchange observed in Clinic-B portrays a mix of operand and operant resources. Apart from the exchange of knowledge and skills, the patients of Clinic-B are observed to choose their healthcare service providers for acquiring better medication, which makes their expectations product-focused along with having a service-centric mindset. The findings chapter of this research discussed a common practice in low socio-economic clinics where general practitioners are found to associate themselves with the 'gift culture', promoting the unethical marketing/dispensing of medicines, to provide higher profits to the pharmaceutical companies against the perks received. To counter the growing issue, the patients in high socio-economic areas are observed to associate with high-end clinics that charge more for the cost of treatment/s but promise quality medicine-dispensing as their service offerings. The product (medicines) is one of the important factors that act as a primary unit of exchange in such clinics along with the operant service offerings. This finding from Clinic-B is seen to associate with the understanding and adaptation of a viable business model for a good service delivery mechanism. Comparing this finding with Vargo and Lusch's (2004) theory, a gap is seen that derides the significance of internal capabilities and the significance of tangible assets. The literature review chapter gave an insight into the findings of Teece (2018) where a good business model is believed to acknowledge innovation but is also required to combine the utilization of tangible and intangible assets for profitability. A similar outcome is noticed in Clinic-B's settings where the top management is seen to utilize both operand and operant resources to secure long-term profits.

Linking the above-mentioned finding with the institutional theory of business, a trend is noticed where the demand from the consumers drives the market that acknowledges both internal and external capabilities for successful operations. Patients from high

socio-economic areas of the developing countries are seen to expect a high role of the mix of operand and operant resources as compared to low-socioeconomic areas or from the patients visiting healthcare setups in the developed countries. Similar to Clinic-A, the market for high-end clinics requires the top management to adapt to the forward integration strategy and dispense quality medicines from inside the facility. The only difference in these settings is that the dispensed medicines are prescribed following the legal criteria and can be purchased from any pharmacy outside the clinic. Furthermore, it is observed that the market for high-end clinics requires the organizations to keep their focus both operand and operant-centric. Unlike Clinic-A, the high socio-economic clinics have to keep a high presence and a balance between their product and service offerings to capture a bigger market share and maintain optimum ROI.

6.6.3 CRITICAL REVIEW OF CLINIC-A & CLINIC-B IN THE CONTEXT OF INSTITUTIONALISM

The last two sections of this research elaborated on how the institutional arrangements differ between high and low socio-economic societies of developing countries. This section, however, will focus on how these findings relate to the literature review discussed regarding SDL and its applicability in healthcare. Recalling the 5th axiom of SDL, "*Value cocreation is coordinated through actor-generated institutions and institutional arrangements"* (Vargo and Lusch, 2015), the two authors are seen to stress upon the need to adapt SDL practice as (according to their study) institutional arrangements present in the current world markets demand a service-to-service exchange. This statement is backed by the research of Vargo and Lusch (2004), where they have iterated that the market has been transitioning from the product focus to service focus over the past 50 years. Akaka and Chandler (2011) were also seen to deliberate on the need to adapt to a service focus based on their study encompassing the social and cultural contexts present in the institutional arrangements. To further back their argument, Vargo and Lusch (2015) stated that the service eco-systems represent the assemblages and sub-assemblages of a society. The micro, meso, and macro levels of society were brought in their research to

strengthen the argument of institutions in the service dominant logic (Storbacka, 2016; Vargo and Lusch, 2015). Comparing the development of SDL theory on institutional arrangements and the two case studies explored by the author, a contrasting image is seen to develop.

Before deliberating on the differences that are observed between SDL theory and the empirical evidence from the case studies, the researcher wishes to remind the readers that SDL has been sturdily criticized for overlooking money and profit from its value analysis (Hietanen et al., 2017). The extant literature deliberating on the element of 'institutional arrangements' is seen to pinpoint that the research on SDL theory is mostly comprised of resource-abundant societies, overlooking the outcomes that can be observed for resource-constrained settings i.e., developing countries (Blocker and Barrios, 2015). This lack of economic perspective and the impact it may have on the existence of institutional arrangements in a certain society (Hietanen et al., 2017; Prior and Marcos-Cuevas, 2016) is believed to be the reason why the theory on SDL by Vargo and Lusch (2016) appears to be somewhat abstract.

To begin with, the findings of Clinic-A are seen to reflect that the healthcare markets present in the low socio-economic societies of developing states have not been transitioning to a service focus. Instead, the institutional arrangements observed in these settings pinpoint the efficacy of the GDL approach that works for the benefit of both the service providers and service beneficiaries, as it is designed to meet the needs of this particular market segment. Moreover, the argument brought in by Vargo and Lusch (2015) that, activity at one level (micro, macro, or meso) can only be adequately understood by also viewing it from other levels, which they referred to as '*oscillating foci*'. Hence, it can be understood that the service providers and service beneficiaries demonstrating a GDL mindset in a B2P market (at the micro-level) are relative to the meso and macro levels of society. This statement is found true to much extent as the norm/behavior of service actors observed in the low socio-economic healthcare clinics and the overall low-income societies point towards the same institutional arrangements. Norms, culture, financial backgrounds are not only applied to a particular B2P relationship (micro) but are evident in the mid-range structures (meso) and the broader societal structures (macro). Although the element of institutions and institutional arrangements seems to apply in determining value creation in the developing states, it is not seen to back the theoretical framework of

Vargo and Lusch (2004) regarding the usefulness/adaptation of SDL (according to the findings of Clinic-A).

Findings from Clinic-B are interesting in a manner that they back the theoretical framework of SDL to some extent. Though some major variations have been observed that point towards the inefficacy of SDL to be taken as a viable lens for applicability in the developing world. Getting into further depth of this point, the researcher observed the 'focus on services' to be quite high amongst the interviewed patients of Clinic-B. The institutional arrangements observed in these settings also pinpointed that having SDL mindedness (by top management) is a viable approach as the service actors were seen to engage with one another on multiple levels to cocreate value. Exchange of skills, knowledge, and learning between service actors are some of the factors that the researcher observed on the micro-level (Clinic-B). On bigger levels (meso and macro), the researcher was able to explore some pieces of literature (Angeli and Jaiswal, 2016; Mustafa et al., 2018) that advocated such social constructs to be common in high socio-economic societies (in developing states). This finding helps to understand that the norms/practices observed in Clinic-B (micro-level) are relative to the social constructs prevailing in high socio-economic societies of developing countries (Vargo and Lusch, 2015). The differences observed between the institutional arrangements of socio-economic societies are therefore seen to create different market segments in healthcare, leading to customer segmentation (as mentioned earlier).

In contrast to the similarities observed in SDL theory and the empirical evidence from Clinic-B, the researcher was able to identify certain institutional arrangements that accounted for product centricity to be an integral part of this society. Vargo and Lusch (2004) regarded products as 'complimentary' to the service/s provided, however, the researcher observed the inclination of patients in Clinic-B towards products as one of the primary units of exchange. This inclination, in the light of collected evidence, can be best explained to occur because of the macro impact that the societies demonstrate due to the institutional arrangements present in them. As aforementioned, the high socio-economic society encompassing Clinic-B expects a mix of operand and operant resources to satisfy their healthcare needs. To fulfill this void, the management of Clinic-B is observed to adopt a business model that is effective in providing a mix of GDL and SDL ways of marketing.

Axiom 5 (Value cocreation is coordinated through institutions and institutional arrangements) of Vargo and Lusch's (2016) most recent publication of their conceptualization of the SDL theory, indicates that all cocreation must be based only on SDL approach, based firmly on operant orientation and resources. However, the empirical evidence suggests that it may not be true in all cases for example, as discussed above, the value perception of patients in Clinic-A strongly identifies a satisfactory value cocreation episode based on the GDL approach, largely involving service provision that is operand focused, in terms of orientation and resources. Whereas the customers of Clinic-B tend to expect a more service-oriented approach, as discussed above, they place equal value on the product and service exchange. Therefore, institutional arrangements may significantly differ with respect to separate customer segments. This means that the researchers should consider the institutional arrangements of not only sectors (e.g., healthcare), and geographical location (e.g., Pakistan or a similar developing country), but also specific market segments. The reality appears to be that institutional arrangements particularly are far more complex than the one-size-fits-all conceptualization offered by Vargo and Lusch (2016).

As the empirical evidence from Clinic-A suggests, the institutional arrangements present in society lead towards 'driving' a B2B competition and GDL approach of marketing, the institutional perspective of SDL is thus seen to be refuted by the very authors (Vargo and Lusch, 2015) who suggest that "*…rather than being existing structures that are entered and characterized by competition, markets are envisioned and created through institutionalization".* Similarly, the statement by Vargo and Lusch (2015) that, *"Value cocreation can only be fully understood in terms of integrated resources applied for another actor's benefit (service) within a context…"*, does not seem to apply in developing states due to the factors unconsidered by the authors (limited to the studies in developed states).

As suggested by the literature on SDL in developed countries, the role and applicability of SDL might be fulfilled by service-to-service exchange (Joiner and Lusch, 2019; Ng and Vargo, 2018), but the same is not possible in the developing countries due to the prevalent factors such as norms, customs, beliefs, and culture, etc. A description is thus presented by the researcher below that aims to discuss the role and applicability of SDL in developing countries.

6.7 SDL IN DEVELOPING COUNTRIES

From all the acquired evidence, the main factors to evaluate mutual value creation between the service provider and beneficiary in developing countries are seen to rest on the perceptional, technical, and financial value of the service exchange. The foremost need for understanding is that the healthcare market of developed and developing countries differ immensely from one another. In that scenario applying the SDL's 'one-size-fits-all' approach can be seen as misleading and unauthentic. Conducting 2 case studies in a developing country has worked to create awareness regarding the special considerations which would serve as empirical evidence in measuring cocreation of value. This also has resulted in addressing the need as to how SDL could be modified to be evaluated and implemented in developing countries.

Exploring case studies within a developing country has highlighted the significance of 'financial value', which makes the findings on SDL in healthcare, completely different from the ones studied in the literature of developed countries. 'Cost of treatment' has been highlighted as a major factor which the residents of developing states have to bear in mind as opposed to the patients living in the developed countries. This factor is seen to automatically add an extra element of 'financial value', which the patients of developing countries keep into context when obtaining healthcare services. Another finding that has broadened the scope of this research is based on the different-tier markets operating inside the developing countries. The author has explored 2 types of private healthcare markets that operate in developing countries. The differences in both of these markets are seen to emerge due to socio-economic reasons and the target audience is found to be different for each of these studied clinics. This study not only helps to highlight this component of value for the patients and service providers in the developing states but also provides findings on how much impact this component makes on the value cocreation between the involved actors. Literature from the developed countries highlighted that 'financial value' does not apply in most of the cases as the patients are either covered by health insurance or have free access to quality healthcare (Osei-Frimpong et al., 2018). Alternatively, scantly available literature on developing countries and the explored case studies have highlighted that the cost of treatment may alone act as a deciding factor for the beneficiaries to choose, deny or keep on receiving healthcare services.

Private healthcare, being the most popular choice for obtaining healthcare, further demonstrated two different markets catering to the patients based on socio-economic differences. While the high-income healthcare customers demonstrated ‘similar’ traits to the patients residing in developed countries, the general population belonging to lower-or-middle-income households exhibited completely different traits of value perception.

In terms of Clinic-B, the perceptional value of patients is seen to differ from the ones in Clinic-A. The value for these patients is recorded to be similar to the ones residing in a developed country. Moreover, the impact of the financial value is seen to less impact the healthcare customers visiting this clinic. It is therefore validated that the institutional beliefs of the clinic and patients are harmonized to focus on the value propositions in terms of more sharing of knowledge and quality-based services. This finding is also associated with the attributes of the patients visiting this clinic. High knowledge regarding their respective ailments and more access to education has made these patients self-aware and demand a higher quality of services as compared to the patients in Clinic-A.

6.8 DETERMINING SDL IN CLINIC-A AND CLINIC-B

As the role and perception of value are now fully contextualized to the healthcare sector in developing countries, the researcher believes it is important to have another look at the presence of SDL within both the healthcare clinics. Discussing these findings with contextualized value will help to portray a truer picture of how the cocreation of value takes place in developing countries.

6.8.1 ANALYSIS OF CLINIC-A AND B BASED ON SDL COMPARISON FRAMEWORK IN HEALTHCARE

The researcher, while presenting the foundations of the SDL conceptual framework in healthcare, explained the significance and role of contextual and value cocreation dynamics for determining the overall value creation in the healthcare setups. It was

deliberated that **Value Cocreation Dynamics** are the elements that the author believes to carry high significance when determining the cocreation of value in healthcare settings. These dynamics can be understood as the transactional intricacies through which services are exchanged between the two actors (Healthcare organization and the Patients) Moreover, the author explained that **Contextual Dynamics** can be understood as the behavioral/cultural intricacies that develop from the perceptions of actors towards service delivery and service relations. To understand the presence of SDL in the exploratory studies, it is important that the findings of Clinic-A and Clinic-B are compared under each component of the model, and both categories of the above-mentioned dynamics. As the element of value perception is already contextualized to the developing countries (in the sections above), the findings from the SDL framework are believed to be more authentic and relative to explored clinics. Starting from the contextual dynamics of the model, the following analysis has been presented:

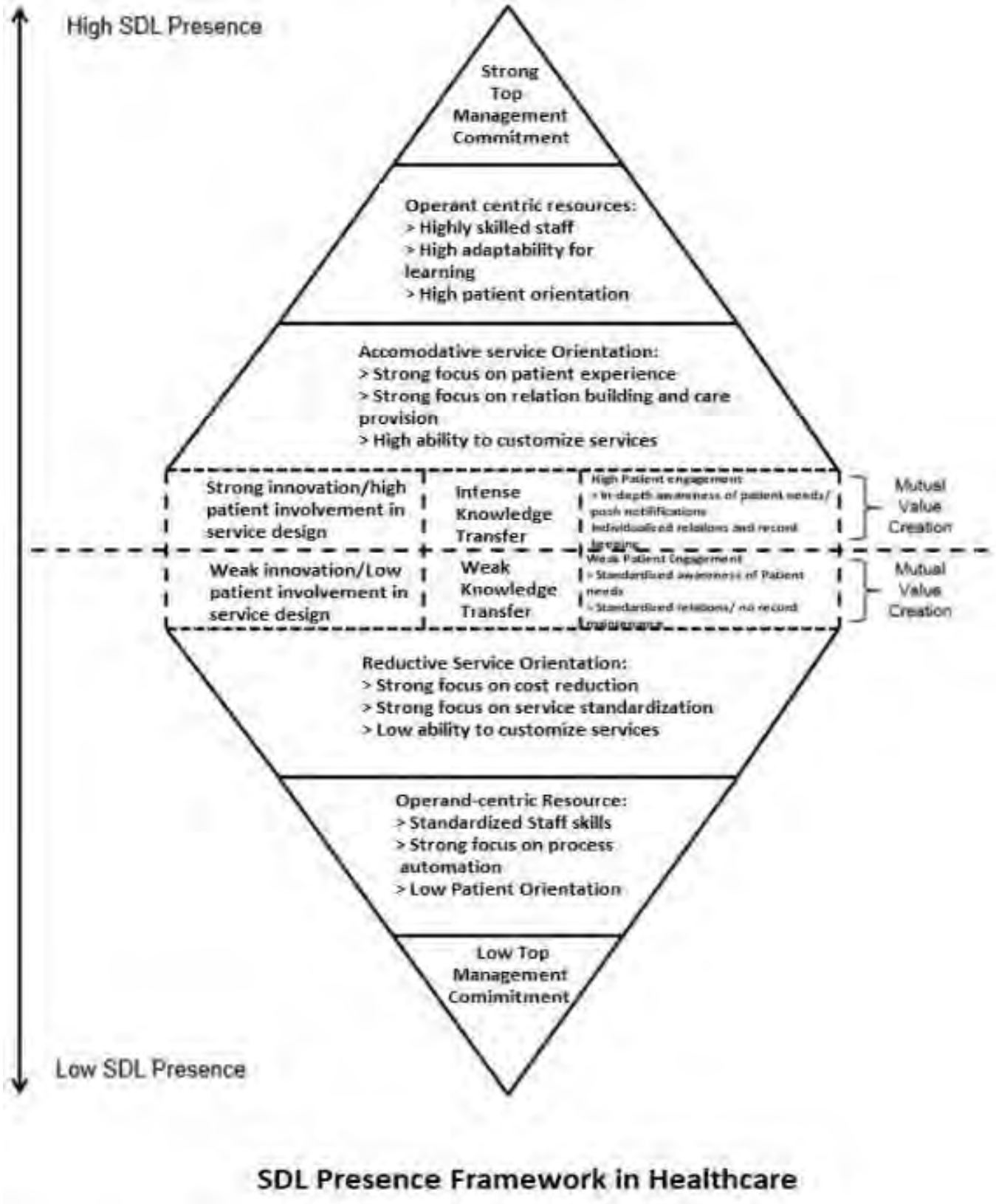


FIGURE 6.1: SDL Presence Framework in Healthcare

TOP MANAGEMENT COMMITMENT (TMC)

The findings for Clinic-A demonstrated a scenario where a weak commitment from top management was observed in terms of service delivery. It is observed that the management of the clinic has higher interests in terms of cost savings rather than providing better value propositions to the associated patients. For deeper understanding and analyzing accurate findings, TMC is observed in 4 different aspects. The first aspect, TMC towards staff, is observed to depict a scenario where the top management is not using operant centricity towards transferring knowledge and skills to the staff. Therefore, an environment is observed, which is deprived of a training department (HR), that could help in training the existing staff of Clinic-A. Following the traditional and old system of service delivery with no will to upgrade or enhance 'human skills' is the main factor observed for lower value creation between the service provider and service beneficiary. The literature section highlighted the role of successful service organizations where the employees show a tendency to innovate and learn within the working environment (Ashill et al., 2008). Such behavior is demonstrated where the top management is observed as being focused and committed to providing advice, opportunities, and training to the existing task force. However, the organizational culture observed in Clinic-A demonstrated a weak institutional arrangement where the clinical staff was unaware of basic knowledge such as the company's vision or mission statement. An important finding that validates the lower presence of SDL in Clinic-A is the patient satisfaction response, obtained from interviewing the visiting patients inside the clinic. A concerning figure of 30% dissatisfaction towards staff behavior was discovered that points towards low commitment from top management for providing the services to the patients. Moving on to the second aspect, TMC towards technology and innovation, a first glance inside the clinic represented a decades-old traditional system of service provision. A technologically handicapped clinic setting was observed that lacked even basic computer systems for administration and patient handling. Interviews with stakeholders further revealed their intentions of 'no will to upgrade' the existing setup with the reasons based on the cost allocation that would be required for such a change. Knowledge transfer, being an operant resource, is seen to be completely disregarded in similar setups of the developing countries, especially due to a higher focus towards on cost penetration strategy of business management. Several missed opportunities

for value creation are evident from the conditions of such clinics where maintaining patient health records, providing better administration, an effective appointment system, and the management of the company's demand and supply are observed to be absent. Cases of mismanagement have also been reported during the exploration of Clinic-A, which point towards lower value creation, mainly because of the lower TMC that the organization puts forward. The third and fourth aspects, TMC towards relation-building and individual effort of stakeholders, can be looked at together to analyze the findings from the first case study. It is observed that the stakeholder himself is committed to a better value proposition, but the same mindedness is absent in the overall organizational culture. The CEO is seen to build a relationship with the patients on an individualized level, yet the staff is either busy with excessive workload or untrained to share the same goals.

The second case study is observed to depict stronger TMC towards service provision, resulting in higher value creation amongst the service provider and service beneficiary, and consequently is reflected in the patient responses received by the researcher during investigating Clinic-B. Observation of TMC in Clinic-B with the (previously mentioned) 4 aspects is seen to again provide a deeper perspective of how SDL presence is perceived to be advanced due to higher value creation recorded between service providers and beneficiaries. Staff trained by the HR department for effective provision of services is observed to better share knowledge (operant resource) with the patients and build a stronger relationship with them. Tools such as seminars, workshops, and training sessions are the methods chosen by the clinic's top management to enhance the internal capabilities of the organization. This 'sharing of goals' is recorded by the researcher amongst all the employees of Clinic-B, who are aware of their job roles, company's vision, and mission statement. Comparison of the findings of Clinic-B with studied literature affirms the arguments by Vargo and Lusch, (2019) where the SDL approach is observed to be embedded within the DNA of all organizations. This points towards a positive and strong institutional arrangement that binds all the actors (staff and patients) with one another for the aim of value cocreation.

Moving towards the findings on technology, innovation, and the role of TMC, it is seen that effective allocation of resources (operand) is made to deliver (operant) resources to the customers. As this service business requires an exchange of operand and operant resources (previously explained), the top management is observed to invest

in *superior resources* (Teece, 2018) for value creation. Although the concept of superior resources (operand) is used mainly for explaining the GDL approach of marketing, the findings from Clinic-B depict its use (collectively with) the aim of improving service quality and skills of its employees (operant). This finding is seen to affirm the concept of 'dynamic capabilities', which generally is based on the mix of operand and operant resources (internal and external capabilities) of an organization, rather than arguing on the superiority of one concept over the other. Another significant evidence of higher SDL presence is gathered from the role of suppliers in Clinic-B that relates with the examined literature. Vargo and Lusch's (2004, 2008, 2015) articles have repeatedly stressed the collective contribution of multiple actors in a service ecosystem for value cocreation. This concept is seen to fit perfectly in the case of Clinic-B, where the supplier's input for innovation is not only welcomed but is also implemented by the top management. Interviews with the CEO revealed that the majority of clinical innovation is the result of suppliers' advice and knowledge sharing (operant), which led to improvement in the service offering of Clinic-B. The third and fourth aspect in this regard is also seen to complement the literature already available for the role of TMC in SDL presence. The focus of top management towards relation building is seen to be practiced amongst all the staff working in the clinic. Moreover, the CEO and other stakeholders are found to personally engage in informal and formal communications with the patients to share knowledge, establish trust and care, and pave the way towards a stronger relationship.

RESOURCE ORIENTATION

Determining the resource orientation of a healthcare organization is a complex process that is based on multiple interlinked factors. In simple words, a patient-oriented firm is perceived as an entity that demonstrates an operant-centric orientation of resources, leading towards the value creation between a service provider and beneficiary (Sears, 2016; Joiner and Lusch, 2016; Ojasalo, 2001). This statement deepens the horizon of the research with the necessary understanding as to what qualifies as a patient-oriented firm? Sears (2016) is seen to argue that a patient-orientated healthcare model can be perceived as one in which patients are at the top of the system. 'Patients being on the top' is seen here to denote a scenario where

organizations are accommodating all the service needs of patients through the use of their resources. This understanding, in turn, adds another requirement to comprehend how and when the resources of an organization accommodate patients, exhibiting a higher SDL presence. The findings from Clinic-A and Clinic-B, hence, serve as the best exploratory sources to identify the empirical evidence required for the identification of SDL presence in healthcare setups. An overall understanding that comes out from the findings of both clinics is that the organizations which accommodate resources to propose value, focus more on the adaption of operant-centric approaches rather than operand-centricity. Vargo and Lusch (2015), while discussing such organizations argue that operant-centric resources are abundant in service-centered setups, leading towards mutual value cocreation.

Studied literature has affirmed that the employees of an organization are its tangible resources. If this statement is taken into context, the next important aspect to understand here is, how and if, the employees (tangible resource) can act as a source of 'strategic benefit'? (Vargo and Lusch, 2004). This again is argued in the literature by both authors that, *"In a service-centered view, tangible goods serve as appliances for service provision rather than ends in themselves"* (Vargo and Lusch, 2004). The understanding affirms that the exchange of skills or the transfer of knowledge and information by employees falls under the category of operant-centric resources. Moreover, it also implies that the resources must be coordinated and developed to serve (exchange) desired benefits to the consumers. Hence, it can be deduced that the employees (being an operand resource) can exhibit an operand-to-operant exchange, given that the resource networks are established and outsourcing of necessary skills and knowledge to the network is being met. This aspect is crucial to highlight in the discussion section because the 'capabilities' of hired staff demonstrate if the organization is operant-centric or simply an operand-centric entity. Henceforth, the researcher has tried to evaluate the presence of SDL in the studied case studies based on the understanding noted above.

It is observed from the findings that the organizational culture of Clinic-A reveals certain practices and norms which can be seen as the reasons why some clinics demonstrate a lower presence of SDL than the others. For example, the staff of Clinic-A is seen to make use of standardized skills by following standard operational protocols (SOPs). This signifies that the hired staff of Clinic-A strictly adheres to the

SOPs for providing healthcare services to patients and this, in turn, hinders their learning for innovation. Demonstrating such behavior in the clinic can also be seen as the reason why the employees fail to exchange knowledge and information with the consumers of healthcare. Process automation and standardization of services are the reasons observed to hinder individualized service provision in this clinic. This is seen to lead towards operand-centric orientation as the exchange of knowledge is only possible when services are tailored according to an individual's needs. With a high influx of patients to the clinic, the staff has been observed to ignore individual attention, leading towards lower value creation with the service beneficiaries. This practice is criticized by researchers for restricting the path towards value creation with patients (Yan and Kung, 2018; Ojasalo, 2001), hence, the observations from Clinic-A can be seen to validate the literature arguing for individualized service provision for value cocreation.

Alternatively, the researcher observed operant-centric commitment from the top management of Clinic-B. A high organizational focus towards service satisfaction and prioritization of patients has been detected, demonstrating that patients are kept at the top of the system. The first observation in this regard is the TMC for hiring skilled staff. It is noted that the presence of an 'HR department' ensures the proper training of employees with instilling skills that are necessary to perform their job/s in this clinic. Consequently, the staff of Clinic-B is seen to demonstrate the 'will and skills' to adapt and react to any situation that presents itself inside the healthcare facility. The skills, whether associated with communication, care, or relation-building, result in sharing of knowledge and create value for both the firm and the visiting patients. As the ability of employees to learn and adapt is considered to be an important factor for determining the presence of operant or operand centricity (in context to resource orientation), Clinic-B is found to be successful in mutually creating value with the associated patients. Furthermore, an important understanding is seen to come out by evaluating the resource allocation of Clinic-B and its relationship with value creation. It is observed that the main element for this clinic to exhibit an operant-centric resource allocation is directly linked to the communal beliefs, norms, and values of the actors associated. A collective effort (and mindset) is witnessed from the patients, staff, and top management of the clinic, paving way for operant-centricity and consequently, leading to higher value creation (between all actors) and advanced patient satisfaction

rates from the service beneficiaries. Subsequently, this finding points towards the significance of institutional theory when it comes to evaluating the presence of SDL in a service organization. The main aspect that is crucial to understand from the findings is the role of patients (service beneficiaries), who are part of the service ecosystem and important actors whose norms, beliefs, and values are integrated with the institution.

Lastly, the findings from both clinics reveal that the mix of both operand and operant resources is necessary to yield a higher presence of SDL in healthcare organizations. Higher cost allocation for tangible assets such as, expensive machinery and staff is observed to aid in the service exchange which helps the firms to maximize their utility. Clinic-B is seen to successfully demonstrate a higher presence of SDL since the management has allocated high-cost tangible resources (machinery), which aids in the delivery of healthcare services. Alternatively, Clinic-A is seen to focus more on cost reduction and having tangible assets of inferior/low quality. This strategy is observed to restrict the service exchange, resulting in lower value creation with the patients. Interestingly. this finding goes against the notion presented by Vargo and Lusch (2004, 2008, 2015, 2016), who stress achieving high operant centricity to attain an advanced presence of SDL in an organization. On the other hand, if compared to the literature by Teece (2018), relevance can be seen with the concept of 'dynamic capabilities' that argue for the use of both operand and operant resources to maximize the value propositions. From the collected evidence it can thus be deduced that a mix of operand and operant resources is seen to justify positive outcomes in terms of value creation, rather than ruling out the significance of operand resources.

SERVICE ORIENTATION

The concept of accommodative service orientation has been deliberated in the previous sections of this research. In essence, it is learnt that service organizations aim to accommodate customers and cocreate value mutually for customer retention and long-term relationships. Moreover, it is understood that SDL in healthcare is not measured by utter professional or functional care following the instrumental standards. Patient care experience is the cocreated value and a combination of ethical and

emotional aspects that contribute to the service outcome. In consideration of the ideology, it is observed from the explored case studies that service orientation plays a huge part in analyzing the extent of SDL presence in a firm. The deciding factors for a healthcare service firm to cocreate value are based on the focus on service experience, the effort put in relation-building and care provision, and the ability to customize services for the patients. In this regard Clinic-A is observed to be lacking in providing the best service outcome for the patients and concludingly, failing to cocreate value with the patients.

The findings from Clinic-B demonstrated a scenario where value creation between the clinic and patients was recorded to be very high. Numerous factors pointed towards the accommodative service orientation that the clinic is seen to portray. The main factor that came to light is the heightened focus on patient experience. An overall service satisfaction of 42% demonstrates how much the clinic has invested in terms of care and experience. The major reason for this satisfaction percentage comes from the collective 'technical' and 'perceptional' value of the actors, as discussed previously in this section. The important point to realize at this point is that the firms who invest in providing quality services, enhanced patient experience, and provide the real essence of care, tend to achieve a higher cocreation of value with their patients. These approaches have a facilitating impact on relation-building and care provision, as seen from the findings collected from Clinic-B. The higher focus on service provision increases the chances for the clinics to maintain a good relationship with the patients. In return, the patients are seen to feel valued for the services they acquire. Moreover, accommodating patients has been seen to only be possible when the services are customized according to their individual needs. As healthcare consumers are deliberated to be different from the conventional business consumers, it is observed that the requirements for such patients can only be met when they are provided with customized services. Doing so places the firm at the top of the SDL presence framework and ensures effective value creation between the service provider and beneficiary.

While exploring Clinic-A, the author observed reductive service orientation which is seen to be based on the fact that the clinic is offering poor service quality due to its cost minimization approach. As there is mounting evidence that the perceived quality of healthcare services has a relatively greater impact on patient behaviors, for

example, satisfaction, choice, usage, etc. (Andaleeb, 2001), the value created between the provider and beneficiary is seen to be majorly impacted. The clinic is observed to standardize its services to reduce its operational costs. This practice is seen to lead towards lower learning opportunities and consequently, leading to offering lower value propositions to the customers (in terms of service experience). Similarly, the provision of quality services is also seen to be compromised due to the strong focus on cost minimization. Interestingly, operand-centric behavior from the service provider (Clinic-A) is seen to originate due to the mutually followed institutional arrangements present between the service actors. It is noted that financial value plays a bigger role in such settings, as per the requirements of the patients, and the overall quality of services (for example technical value) is seen to hold less importance than the overall cost of treatment. Reductive service orientation is hence, noted to act as a solution for both the service actors (service provider and beneficiary) in lower-end healthcare clinics of the developing states, to keep the operational and transactional costs at their lowest. This finding leads to questioning the authenticity of SDL in the developing world where the central role of service is observed to be substituted by the cost of treatment when it comes to value creation. Further depth into this finding in the upcoming sections is necessary to understand if 'value' can be seen as subjective to the recipient audience.

Analyzing the findings regarding the use of resources in Clinic-A and Clinic-B, the crucial understanding that has come forward is that the organizations which demonstrate accommodative service orientation, tend to achieve higher value cocreation with the patients. Alternatively, and according to this logic, demonstrating reductive service orientations should demonstrate lower value creation with the patients. However, the factors of institutional arrangements are observed to play an important role that leads towards substitution of value proposition, which is seen under the components of 'financial' and 'perceptional' value. It is observed that Clinic-A substitutes its value propositions from service quality/experience to offering lower-cost treatments. Consequently, the patients are observed to keep their association with the clinic based on the element of financial value. Value creation is therefore seen to still take place, even when the service orientation is compromised due to numerous reduction strategies. Although the value created in Clinic-A is not recorded to be immensely high, it still challenges the notion of SDL theory which puts service at the

heart of organizations for value cocreation. Under such circumstances, it has become necessary to explore the role of value and its relationship with 'service' to understand the applicability of SDL in the developing world.

PATIENT INVOLVEMENT IN THE SERVICE DESIGN

Findings from explored case studies have highlighted the fact that there is an immense difference between Clinic-A and Clinic-B when it comes to involving patients in the service design. It is noted that Clinic-A provides basic services to the patients that can be best described as 'standardized' in nature. Due to the cost reduction model that is being followed, there is no room for flexibility that could result in shaping up the service delivery according to the involvement of the visiting patients. As discussed in the previous section, patient involvement in the service design and innovation are closely related to one another. Lower/negligible involvement from the patients is seen to result in no noticeable innovation that could be recorded in Clinic-A's service delivery. It is discovered from the collected evidence that the target audience of Clinic-A falls under the category of low socio-economic groups, who are more concerned with the financial expenses related to the cost of treatment as compared to the design of the offered services. According to the studied literature, such findings contribute towards lower value creation between the service provider and beneficiary. Therefore, the value creation between this dyad is recorded to be lower in Clinic-A as compared to Clinic-B, when observed under the constructs of SDL presence framework in healthcare. Consequently, this approach is expected to affect the patient retention rate, which can result in losing clients based on lower value propositions. However, the findings from Clinic-A have demonstrated that the patients still preferred to associate with the clinic based on their value perceptions, which are driven by other over-shadowing components. These findings suggest that there are other factors present in the private healthcare of developing countries that substitute the value creation between service actors as opposed to the components highlighted in the SDL theory (Vargo and Lusch, 2004).

Alternatively, the management of Clinic-B is found to associate itself in numerous activities that improve the chances for patients to engage in service designing, or re-designing of the existing services. From the collected evidence in the previous section,

it becomes evident that both healthcare setups are following a different management approach and targeting, unlike consumers as their target audience. Moving forward, it is discovered that the 5 main components of the offered services in Clinic-B (Emergency, Clinical, Laboratories, Surgical, and Catering) have inputs from the patients, who have been noted to actively participate in the service design. The active participation of patients is seen to result in advanced value creation between the service actors and an environment of high patient satisfaction is thus recorded. As patient engagement is seen to fall under the category of value cocreation dynamics, it is noted that Clinic-B exceeds in creating value (dyadically) with the associated patients. The success of Clinic-B as a service business can be attributed to the fact that the customers of healthcare are provided with opportunities to involve themselves with improvement/alteration of the service design. Consequently, this business practice is seen to lead towards service innovation, which has been recorded within various domains of service delivery structures present in the organization. An important factor that has surfaced from the exploration of Clinic-B is seen to point towards the connection between socio-economic conditions of the patients and the service delivery mechanism of the service provider/s. It is noted that the high-income societies of developing countries base their value perceptions based on how high their involvement in the service design is being met. This behavior is salient to the theory on SDL by Vargo and Lusch (2004, 2015) and is also observed in the explored literature of various other scholars (Patrício et al., 2018; Storey and Larbig, 2017).

Comparing the element of 'patient involvement in service design' has led to an understanding that both healthcare clinics exhibit different strategies, which seem to work for them in terms of securing profitability. Clinic-A is observed to demonstrate lower value creation with the patients but has still managed to retain an association with the visiting patients. This finding requires a deeper study to find the reason for this outcome and will be discussed extensively in the next subsection of this research.

INTENSITY OF KNOWLEDGE TRANSFER

Interviews from the patients of both healthcare clinics have revealed contrasting results when compared to one another. Clinic-A (service provider) is found to lack in achieving a high intensity of knowledge transfer with the associated service

beneficiaries. The reasons, as mentioned in the findings chapter, mostly comprise of the fact that the clinic is understaffed, and the GPs have to cut short the consultation times to provide services for all of the visiting patients. A high influx of patients, unavailability of health records, and lower commitment from top management are some of the reasons identified as to why Clinic-A fails in transferring knowledge between the service actors. Further depth into the exploration of Clinic-A has revealed a unidirectional flow of information, moving from the patients to GPs. This finding explains the scenario that patients are the actors who inform the GPs about their ailments or experiences and by doing so, the knowledge is transferred to the service provider. On the contrary, medical practitioners are found to restrict the flow of knowledge to the patients due to the reasons already mentioned above. This finding suggests low-value creation between the service actors according to the theory on SDL and is mentioned to have an adverse impact on the relation between the service providers and beneficiaries (Yang et al., 2015). As aforementioned, the reason for the uniflow direction of knowledge is mostly attributed to the reason of the institutional arrangements that are present in the low-income societies of the developing countries. An environment is noted to exist in these economies where the GPs have to adhere to the social norms and operate their businesses in a way that is acceptable by all of the actors in a service network.

Alternatively, Clinic-B is found to be efficient in the transfer of knowledge between the service actors. Some important factors resulting in this outcome are noted to be originating from the maintenance of patients' health records, adequate time allocation for doctor-patient consultations, strong commitment from the top management, and HR's role in skills development to share maximum knowledge between the service actors. It is observed that the model on which Clinic-B operates, requires the top management to ensure free flow of knowledge transfer in both directions (in a dyad). The institutional arrangements present in the high-income societies of developing countries are seen to have emerged over time due to the factors of high educational backgrounds of patients, a better understanding of their ailments, and the practice of a healthy lifestyle. Such elements are seen to create an atmosphere where service providers and beneficiaries require an extensive transfer of knowledge between themselves. The top management of Clinic-B is observed to be aware of this institutional arrangement and is seen to promote knowledge sharing through the use

of multiple strategies and platforms. The findings chapter elaborated some of the tools, the top management of Clinic-B has engaged themselves in for this purpose. This includes surveys and questionnaires through which the top management ensures the needs of the patients are being met.

As aforementioned, the transfer of knowledge is seen as an operant resource when seen under the light of SDL theory (Vargo and Lusch, 2004). Moreover, it is understood that the higher the transfer of knowledge is maintained in an organization, the higher the SDL presence is expected to be recorded (Salojärvi et al., 2010). An important finding that came out from the exploration of both case studies lies in the fact that the existing models of both healthcare clinics are highly influenced by the institutional arrangements present in the different socio-economic societies. The value created between the service actors is highly dependent on the needs of the service beneficiaries. Under such circumstances, it is important to understand if the value for the patients living in low-income areas depends on the need for low knowledge transfer. This finding will be extensively discussed in the upcoming subsections of the Discussion chapter.

RELATIONSHIP MANAGEMENT BETWEEN SERVICE PROVIDER/BENEFICIARY

Exploring the case studies has revealed that maintaining a relationship between the service provider and beneficiary means different to both service businesses (Clinic-A and Clinic-B), specifically due to their targeted audiences. Findings have revealed that the clinics which serve high socio-economic societies of the developing countries tend to make business strategies to maintain long-term relationships with the patients. These strategies can be seen in the business's service offerings which include superior service delivery, enhanced service quality, and a higher commitment from the top management. Such service businesses ensure that the needs and wants of patients are understood, acted upon, and met with a service experience that could lead towards a stronger and longer relationship between the actors involved. High interaction with the patients, individualized service offerings, and advanced spending on the business's internal resources are some of the examples that have been highlighted in the findings chapter on the exploration of Clinic-B. Another important

aspect that has come to the surface by the exploration of healthcare clinics is the significance of social and cultural constructs that exist in different socio-economic societies. It is observed that having a long-term relationship with the patients is based on the mutual efforts of the service provider and the beneficiary. For example, Clinic-B has demonstrated better relationship management with the patients based on the understanding that the customers wish to take part in engaging with the services to build a harmonious long-term relationship. High knowledge of transfer is also noted to be one of the factors through which Clinic-B is seen to educate the service beneficiaries regarding what should be expected from the service business and how to communicate any needs/wants in case the patients feel to. Advanced technology is another reason seen in the service structure of Clinic-B which directly or indirectly helps in maintaining a relationship with the patients.

Alternatively, healthcare businesses in low socio-economic societies of the developing countries are seen to focus more on the elements of financial value rather than the actual service outcome to maintain long-term relationships. This model of business is seen to lead towards lower motivation for understanding the variable service needs of the patients and consequently, reduces the transfer of knowledge between the service actors. It is observed that the foremost need of the patients belonging to this socio-economic setting originates from the expenses related to the medical treatments. Under such situations, healthcare clinics (like Clinic-A) are found to rely heavily on market intelligence to keep their treatment costs lower as compared to the ones offered by their competitors. Healthcare businesses understand that financial value is the best instrument through which customer retention can be majorly secured and thus, this strategy acts as a tool for lower-end clinics to maintain good relationships with the associated patients. Furthermore, different social constructs are seen to impact the type of relationship patients expect from the service providers and are evident from the low transfer of knowledge, reported in the findings chapter. It is observed that interaction between the service actors in Clinic-A is low and the flow of information goes in one way i.e., from patients to GPs. As relationship management is a mutual process, patients are seen to avoid engaging with the activities that could improve/change the service delivery, and consequently, it becomes futile for the healthcare clinics to invest in platforms that could help in long-term relationship strategies involving customer engagement. This finding highlights that institutional

arrangements of different societies/settings define and construct the sort of relationships that can be expected between the service actors. Linking this finding to the case studies, Clinic-B is seen to demonstrate the scenario, where investing in relationship management is noted to be necessary for the growth of service business, however, Clinic-A is seen to be bound by patient expectations which demand a lower cost for treatment to maintain relationships. It is noted that all other relation-building strategies, for example, use of technology, surveys, individualized offerings, and customer engagement cannot act as viable options for lower-end clinics due to the financial costs required for its implantation. Therefore, service alone cannot be seen as a medium through which organizations can build relationships with beneficiaries in all (or different) settings, making it a subjective phenomenon.

According to the studied literature, Clinic-B is seen to fit perfectly into the criteria by which mutual value creation can be seen taking place. This is attributed to the reason that the clinic is engaged in activities that base 'service' as the most important aspect in value creation. From service design to providing superior service experience, Clinic-B is seen to build a stronger relationship with the patients, placing it high on the SDL healthcare framework. The strategies observed to build a stronger relationship with the patients are also seen to focus highly on the service outcome rather than any other factor. Contrastingly, Clinic-A is noted to fall on the lower gradient of the SDL healthcare framework due to 'degrading' its service quality, based on financial constraints. However, the role of institutional arrangements is seen to suggest that value creation does take place in the lower-end clinics, but the focus is seen to shift from 'service quality' or 'service delivery' to the cost of service. In the light of the above-mentioned findings, it is become necessary to understand the role of value in developing countries so that SDL and its applicability in healthcare can be verified.

6.8.2 CONTEXTUAL DYNAMICS IN CASES A & B

The previous sub-section explained how the contextual and value cocreation dynamics differ between Clinic-A and Clinic-B concerning the 'SDL Presence Framework in Healthcare'. This sub-section, however, will focus on *why* the variance

in contextual dynamics has been recorded, which in turn would help to determine the respective top management assumptions, resource position, and service orientation.

As aforementioned, Clinic-A exhibits a low top management commitment with a high focus on operand-centric resources and reductive service orientation. If we recall section 6.6.3, the researcher discussed axiom 5 of SDL that pointed out the role of institutions and institutional arrangements for determining the value cocreation in organizations. It was determined that institutional arrangements present in Clinic-A are responsible for the way service beneficiaries and service providers behave within a micro-environment. The same was observed for the meso and macro context by comparing the findings with the available literature on the low socio-economic societies of the developing countries. If all factors are considered, a complete rationale becomes evident in which the top management assumption, resource position, and service orientation by Clinic-A are seen to be justified. Even after determining the apparent GDL approach in Clinic-A, the researcher observed the clinic to demonstrate a positive ROI with continuous growth. The need to shift focus from GDL to SDL is not only seen as a costly transition (by the top management) but a highly risky move as the service actors are bound to the institutional arrangements that drive the way Clinic-A performs.

Moving on to the resource position of Clinic-A, the role of institutional arrangements is again seen to justify the presence of operand centricity as the organization is constrained by the overall social construct. Bringing in technological advancement, for example, is not viable for the organization as the majority of the patients residing in the low socio-economic areas were found to belong to low education backgrounds. This shows that the patients associated with Clinic-A would show reluctance in adapting to the improvement in technology in Clinic-A due to lack of education and exposure to such advancements. The interviewed staff of Clinic-A demonstrated hesitancy to adapt to any technological improvement due to the limited knowledge they possessed by working in low socio-economic societies. Making this change is hence seen to increase complexity in the operations of Clinic-A rather than improving the overall service delivery. Institutional arrangements backing up the strong focus on standardized staff skills and low patient orientation are other reasons why Clinic-A shows variance to the contextual dynamics present in Clinic-B. Concludingly, it can be said that that the service providers and service beneficiaries in Clinic-A are bound in

a *dyad* (Vargo and Lusch, 2004) that is governed by the institutional arrangements present in the society. Low TMC, reductive service orientation and an operand resource position is thus a result of demand and supply that matches the social constructs of that particular society.

Moving forward, the contextual dynamics of Clinic-B are also observed to have developed by the influence of the institutional arrangements present in the high socio-economic societies of developing countries. Strong top management commitment, a mix of operand and operant resources, and accommodative service orientation are seen to highlight the specific needs that are segmented to this particular healthcare market. The macro context observed in the high socio-economic societies of developing countries (Angeli and Jaiswal, 2016; Shaikh et al., 2017) has resulted in shaping up the healthcare markets where contextual dynamics (at micro levels) are showing relativity with the macro and meso levels of the societies. This social construct is seen to have driven by the majorly existing factors such as high education of individuals in society, more focus on the quality of life, preference on knowledge sharing, and lifestyle choices. This finding is backed by the interview of patients in Clinic-B, where 121 out of 250 patients were found to belong to higher education backgrounds. Service delivery in this scenario is thus seen to match the demand of the service beneficiaries and seen to comprise of a mix of operand and operant-centric resources.

Under such conditions, allowing or constricting certain actions (Scott, 2001) has made way for organizations like Clinic-B to demonstrate accommodative orientation and a strong focus towards the top management commitment.

6.9 SERVICE EXCHANGE DYNAMICS IN CLINIC-A & CLINIC-B

Observing the service exchange processes in Clinic-A and Clinic-B requires a clear understanding of mutual value creation, which in both cases portrays a varying pattern as we move from one case to another. Before deliberating on the mutual value creation between Clinic-A, Clinic-B, and their respective patients, it is pertinent to re-highlight the difference between mutual value creation and value cocreation. It is important

because of the various misunderstandings that have been highlighted by Vargo and Lusch (2015) amongst the scholar community. The two terminologies have been misunderstood by scholars on various occasions due to the ambiguity arising from the weakly interpreted definition of value cocreation in the original article by two authors (Vargo and Lusch, 2004), and the subsequent publications. The issue then highlighted by Vargo and Lusch (2015) categorically defined both concepts for clarification and proper understanding. **Value cocreation** is elucidated by the two authors as: "*The actions of multiple actors, often unaware of each other, that contribute to each other's wellbeing*" (Vargo and Lusch, 2015). The important aspect of this clarification denotes input of more than 2 actors, exchanging resources on a macro level. Moreover, this definition removes any misunderstanding that limits value cocreation to a dyad, usually examined between a service provider and beneficiary. Alternatively, **Mutual Value Creation** is clarified in the article by Gronroos (2010) as a micro-level exchange of resources between a service provider and beneficiary, where value is created and shared amongst both the actors (dyadically). It has been deliberated by Gronroos in many articles that 'value creation' is measurable because of its 'micro' level occurrence in nature, whereas value cocreation is difficult to determine because of the impact from various 'macro' factors, that leads to its occurrence (Grönroos, 2017; Grönroos, 2011; Grönroos and Helle, 2010).

Based on observations of the service exchange and inferences around the MVC of both clinics, the researcher noted numerous differences that clarify the empirical grounding of SDL in the healthcare sector. To understand this point, the author of this research explored both case studies (Clinic A and B) to witness mutual value creation between service providers and beneficiaries to find empirical evidence for the occurrence of SDL and value cocreation. Moreover, the elements of value cocreation were studied simultaneously by focusing on service delivery, service design, and the exchanges of multiple actors in this network that deliberately or unknowingly contribute towards each other's wellbeing. Doing so has created synergy between existing literature and the explored case studies and has helped the author to identify the presence of SDL in the healthcare institutions of developing countries.

Referring back to section 2.6 of the literature review, the author presented the SDL presence framework which indicated certain factors that account for achieving a high MVC in a healthcare organization. Among the discussed factors were, strong

innovation/high patient involvement in the service design, intense knowledge transfer, and high patient engagement/individualized relationships. Keeping Clinic-B into context, the researcher was able to identify all the indicators, pointing towards a higher MVC (as explained in earlier sections). From a service exchange perspective, it was observed that the main services processes, such as reception, diagnosis, medicine dispensing, and payment/leaving in Clinic-B added up to create high MVC between the service dyad (provider and beneficiary). This in turn helped in strong relation-building and customer retention for the clinic. Contrastingly, lower MVC was recorded in Clinic-A due to the indicators showing weak patient engagement, lower innovation, and weak knowledge transfer. If both of the cases are considered, a huge difference between the MVC can be observed for the involved service actors. However, it is important to understand that the evaluation of mutual value creation through the said indicators only justifies the theoretical aspect of the SDL theory. This method does not consider value creation that could result from other aspects, for example, institutional arrangements or other marketing approaches such as, GDL, discussed earlier in this section. Referring back to section 6.6.3, the author highlighted how value is subjective and perceived phenomenologically by the context, limited by beneficiaries. Keeping this factor into consideration, it is important to identify if the value is also mutually created between the service provider and beneficiary upon viewing it from another lens (for example GDL). The researcher will discuss these findings in the next sub-section for clarification.

6.10 ASSESSMENT OF MVC WITH CONTEXTUALIZATION TO HEALTHCARE INTHE DEVELOPING COUNTRIES

The previous sub-section highlighted how 'SDL theory' itself is not enough to assess MVC in both healthcare clinics. The fact that both healthcare clinics operate in a developing country, demonstrate differences in the perception of value, and function on dissimilar institutional arrangements, indicates a need for the researcher to contextualize these factors. This sub-section proposes that SDL theory is not a universally generalizable phenomenon and cannot be seen as complete in every essence. Findings up to this point have clarified that the developing world works in

different dynamics as compared to the developed states. Henceforth, assessing MVC with the inclusion of the above-mentioned factors provides an in-depth glance at how mutual value creation takes place in the healthcare clinics (empirical findings) as opposed to how it should take place (by SDL theory assertions).

Referring back to the literature and methodology chapters, the researcher elaborated that MVC in healthcare clinics is an accumulative process i.e., the mutual value creation between service actors accrues from the time patients enter into the clinic up to the point of their departure. As aforementioned, contextual, and mutual value creation dynamics play the most important role to determine how much MVC is accumulated between the actors during the service exchange cycle. Seen through the lens of the SDL Framework, if high levels of SDL orientation are present in an organization this will lead to commensurately high levels of MVC. However, when the accumulation of MVC is observed at all the service exchange points within both healthcare clinics a more nuanced interpretation of MVC dynamics emerges. The findings relating to the accumulation of MVC at discrete service exchange points are discussed below.

6.10.1 ANOTHER LOOK AT MUTUAL VALUE CREATION

Step 1: A comparison of mutual value accumulation in Clinics A & B based on SDL theory

Referring back to the literature chapter, the author mapped several service processes taking place in both healthcare clinics by utilizing an approach developed by Maghamis (2018). The researcher identified four fundamental processes common to both clinics: *service exchange at the point of reception*, *diagnosis*, *medicine dispensing*, and *payment/exit*. These processes can also be perceived as four stages of a service exchange cycle through which all patients visiting the healthcare clinics must proceed. Therefore, the researcher believes that this conceptual approach provides a useful framework for comparing MVC for patients in both clinics throughout the respective service exchange cycles, to estimate the theoretical and empirical MVC curves.

Elaborating on this approach, the author has used the data obtained from interviews, surveys, and observations from both the healthcare clinics, to map the mutual value creation taking place at each stage of the service exchange cycle. This means that 'two' individual curves are traced based on the findings from Clinic-A and Clinic-B, where one curve demonstrates the mutual value creation accumulation (MVCA) at the four stages of the service exchange cycle of Clinic-A and the second curve shows the MVCA for Clinic-B. Figure 6.1 presented below provides an understanding of how service exchange processes in both clinics impact the MVC curve when viewed under the theoretical understanding of SDL. The red dotted line shows how the MVC of Clinic-B should appear if mutual value creation is accumulated for the processes of reception, appointment, medicine dispensing, and payment. Alternatively, the blue dotted line represents accumulated MVC for Clinic-A when observed under the already existing theory of SDL.

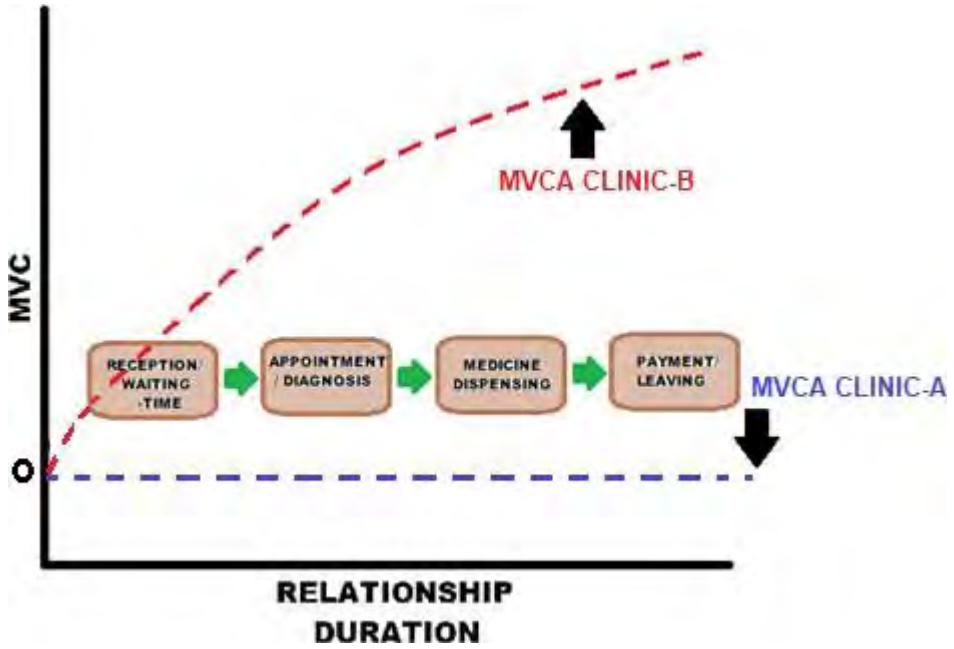


Figure 6.2: MVCA Curves for Clinic-A & B (Obtained from theoretical findings)

Starting from the theoretical understanding, strong patient involvement in service design, intense knowledge transfer, and high patient engagement in Clinic-B are expected to result in an accumulative MVC curve. It is expected that the value is co-created at every service exchange process illustrated in the diagram and therefore,

the red dotted line is seen to justify the acquisitive value creation, increasing with every process shown in the figure. Alternatively, a reductive (or somehow flat) MVCA curve can be observed for Clinic-A that is represented by a blue dotted line. This expected curve is also based on the theoretical findings that suggest low patient involvement in the service design, negligible knowledge transfer, and low patient engagement in Clinic-A.

Having described the comparison of both healthcare clinics concerning the SDL theory, it appears that Clinic-A has failed to provide any value to the patients whatsoever. In reality, it is not the case when compared to the empirical findings that came from exploring Clinic-A. Even though the clinic was found to practice the GDL approach of marketing, the associated patients were seen to create value (MVC) with the service providers based on many factors i.e., financial value, technical value, and perceptional value, etc. This means that assessing MVCA from the theoretical framework of SDL is not a credible approach and value needs to be contextualized to acquire reliable findings. Therefore, the MVCA curve for Clinic-A (in Figure 6.2) can be seen as a signal for the importance of value to come out i.e., it brings us back to the understanding that SDL and GDL approaches of marketing are not either/or strategies, instead, value cocreation should be seen as a continuum running from GDL to SDL.

To verify if value contextualization brings any change to the MVCA (as seen in Figure 6.1), the researcher is going to focus on the individual service exchange processes of the patient cycle in the remaining steps. The approach of this analysis will be conducted to record the MVC for both clinics by including the institutional, cultural, and socio-economical aspects, which are discussed in earlier sub-sections.

Step 2: Service exchange at the point of reception

As the author has previously deliberated that value is a subjective phenomenon, findings from Clinic-A have shown that the GDL approach taking place in Clinic-A is valued by the service beneficiaries due to the social constructs present in their respective society. Patients of Clinic-A are found to perceive value differently for this market segment and hence, the empirical findings suggest a higher MVCA curve for the clinic than the one obtained from examining them under SDL theoretical

framework. By observing the first service exchange process (i.e., seating/reception), it is found that the patients associated with Clinic-A take comfort in the fact that the social norms are being adhered to, and the seating arrangement is designed in a way that gender segregation can be made possible. Data collected from the qualitative research has affirmed that societal values and beliefs are considered more valuable for Clinic-A patients as opposed to the quality of services delivered by the clinic. In Figure 6.3, the author has demonstrated how the institutional arrangements present in Clinic-A impact the gradient of MVCA and how the expected curve (in reality) is supposed to be higher in the empirical settings as opposed to the one observed under the light of theoretical knowledge.

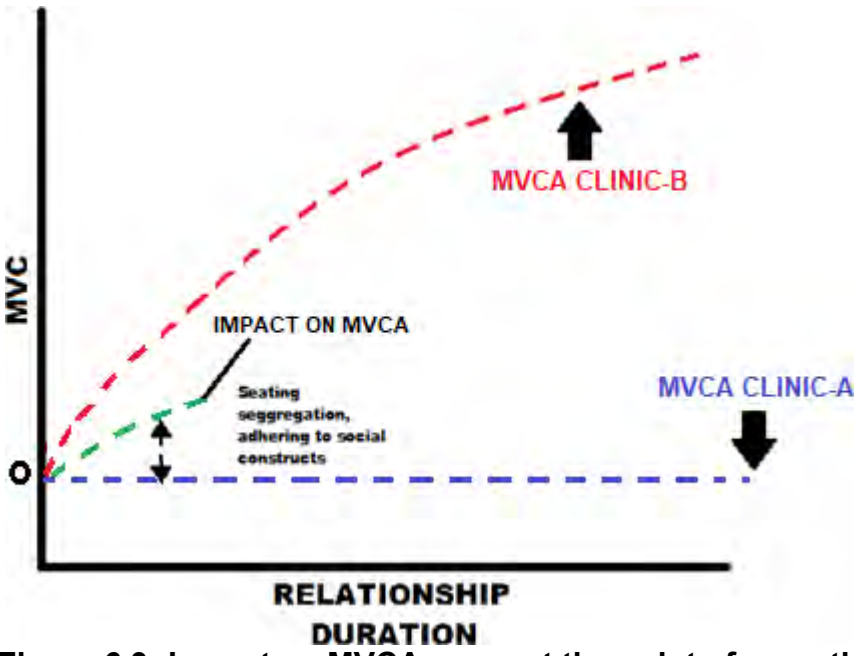


Figure 6.3: Impact on MVCA curve at the point of reception

The green dotted line shows how patients associated with Clinic-A perceive value in reality as compared to the outcomes projected by SDL theory (blue dotted line). Although the new MVCA curve depicts higher MVC accumulation between the service actors, the red dotted line still demonstrates advanced mutual value creation taking place in Clinic-B. This difference in MVCA curves exists due to the factors like service quality, patient satisfaction, and higher accommodative service orientation, as reported by the patients of Clinic-B in the interviews and surveys that were conducted by the researcher. This finding suggests that SDL theory cannot be completely

disregarded in the developing countries and it acts more of a continuum running from GDL to SDL, rather than an absolute phenomenon.

Step 3: Service exchange at the point of diagnosis

The literature on SDL indicates that higher knowledge sharing between the service actors results in a higher MVC (Storey and Larbig, 2017) – a phenomenon observed in Clinic-B. As far as the empirical findings in low socio-economic areas of a developing country (Clinic-A) are concerned, the value perceptions of the patients are found to be heavily reliant on acquiring medication from the GP/s, with as little exchange of knowledge as possible. Reasons for the occurrence of such value perceptions are already discussed in the previous sections which include, lower educational backgrounds of patients, low quality of life choices, etc. For such patients, lower diagnosis times yield higher value creation rather than extensive consultations with the GP. Again, more value is found to be mutually created between the service actors from an empirical point of view and a shift in MVCA is thus seen to be improved from the one obtained from viewing it under the SDL theory lens. In Step 3, the researcher has illustrated this change in Figure 6.4 which is presented below.

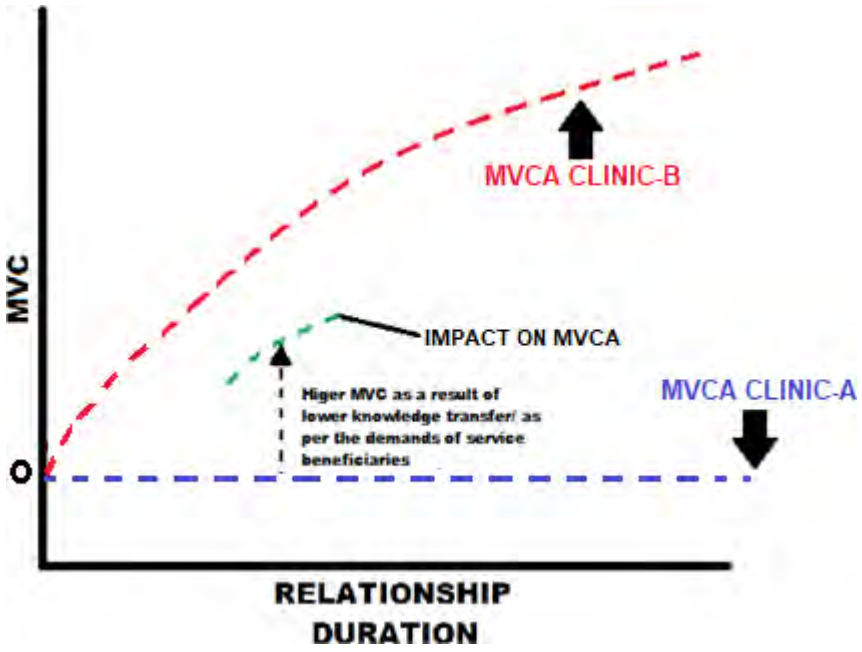


Figure 6.4: Impact on MVCA curve at the point of diagnosis

As shown above, a recurring development in the difference of MVCA curves of Clinic-A and Clinic-B can be observed in Figure 6.4. It is found that shorter consultation times do yield a higher empirical MVCA curve for Clinic-A (as compared to SDL theory), but the amount of value creation observed is still less than the one observed for Clinic-B. This finding confirms that adhering to the SDL theory helps in higher value creation for developing states, yet perceptions that conform to institutional arrangements cannot be disregarded concerning the value perceptions of patients in economically deprived societies.

Step 4: Service exchange at the point of medicine dispensing

As aforementioned, it is a norm in low socio-economic societies of the developing countries to ensure cheap medication provision from within the premises of healthcare clinics. Clinic-A is a prime example in this case, where the service providers are found to be following this practice and providing cheap medication to the patients from the clinic dispensary. In doing so, the clinic may appear to compromise on the quality of medication by offering unbranded, cheap medication, etc. Although this approach seems purely product-centric (GDL) it may still be interpreted as the provision of mutual value. The lower-priced medication enables Clinic-A to provide a cost-effective service, deliver patients with affordable medication from within the clinic, without the inconvenience of then having to take a prescription to an external pharmacy. Therefore, it can be said that in contrast to the SDL theory, the GDL service-oriented service strategy is seen to increase MVC between the actors associated with Clinic-A. The quality of services is found to be of lesser significance to the customers as compared to the value that the patients of Clinic-A are seen to perceive in terms of financial relief and service convenience. The effect of this social construct in Clinic-A and its impact on MVCA is portrayed in Figure 6.5 below. Step 4, therefore, demonstrates how MVCA is increased when institutional arrangements are regarded in an organization.

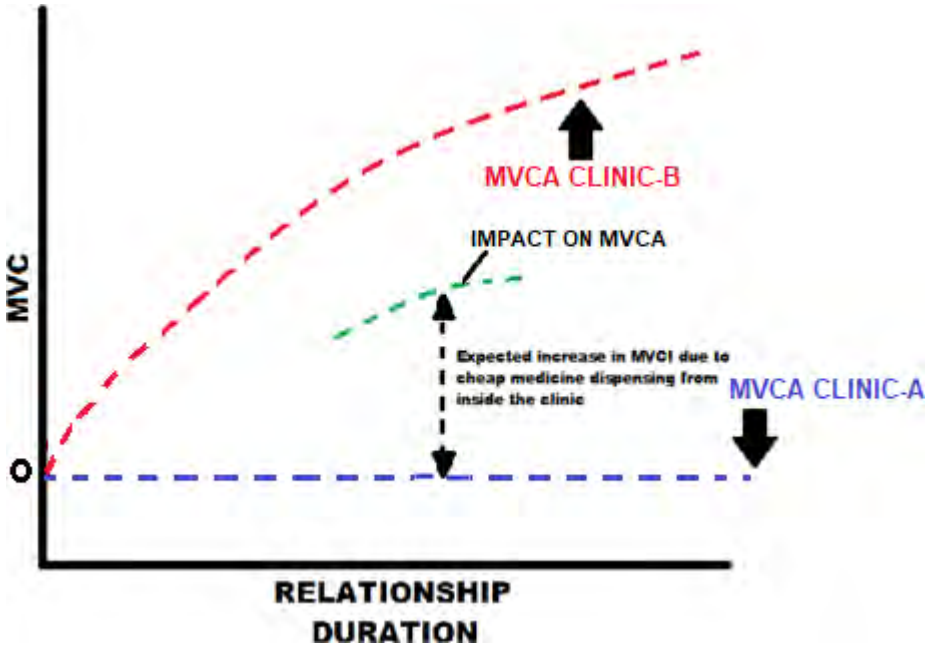


Figure 6.5: Impact on MVCA curve at the point of medicine dispensing

Just like the first two stages of the patient cycle, the uplift of Clinic-A's MVCA curve is not as high as the one recorded for Clinic-B. The reason for this difference is based on the responses received from the patients of Clinic-B, who not only have the option to buy medicines from the clinic's pharmacy but also regard acquiring branded medication from the clinic as an important element of value utility. The findings illustrated by Figure 6.4 show that a GDL approach did help Clinic-A in creating a somewhat higher level of MVC, but that the SDL approach (applied by Clinic-B) generated higher levels of MVCA due to the provision of the kind of quality-of-service delivery expected by that particular customer segment.

Step 5: Service exchange at the point of closure

A discussion of service exchange at the point of closure/payment can be divided into two components: the first is related to the financial value for obtaining healthcare services, and the second is with any post-treatment services or relation-building measures by the clinics. Previously discussed findings revealed that the 'cost of treatment' plays the biggest role in deciding which healthcare service provider, the patients (in low socio-economic societies) will want to receive. Alternatively, it was

found that the cost of treatment has a negligible impact on more finally affluent patients whose satisfaction depends more on how customized their post-treatment care is. As evident from figure 6.5 below, the patients in Clinic-B are found to cocreate value based on the post-treatment services and relation-building measures they receive. The MVCA curve of Clinic-B depicts SDL to be followed throughout the hierarchy of the clinic. Whereas the inclusion of the element of financial value for Clinic-A shows elevation in the MVCA curve of the clinic, as opposed to the one expected from SDL theory. The change is depicted in Figure 6.6 below.

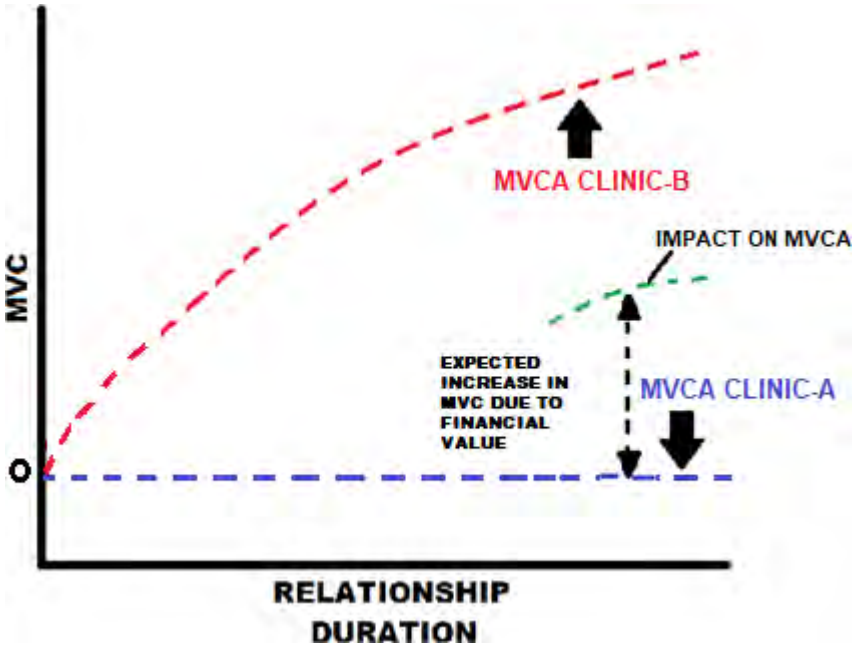


Figure 6.6: Impact on MVCA curve at the point of closure

<u>Step 6: A revised comparison of mutual value accumulation in Clinics A & B based on empirical evidence</u>

As the impact of service exchange processes in a patient service exchange cycle is now evaluated more firmly in an empirical context, the researcher shows below how an overall comparison between the MVCA of Clinic-A and Clinic-B would appear if the institutional arrangements, cultural and social aspects are considered. Figure 6.7 is intended to demonstrate the empirical findings in a graphical arrangement.

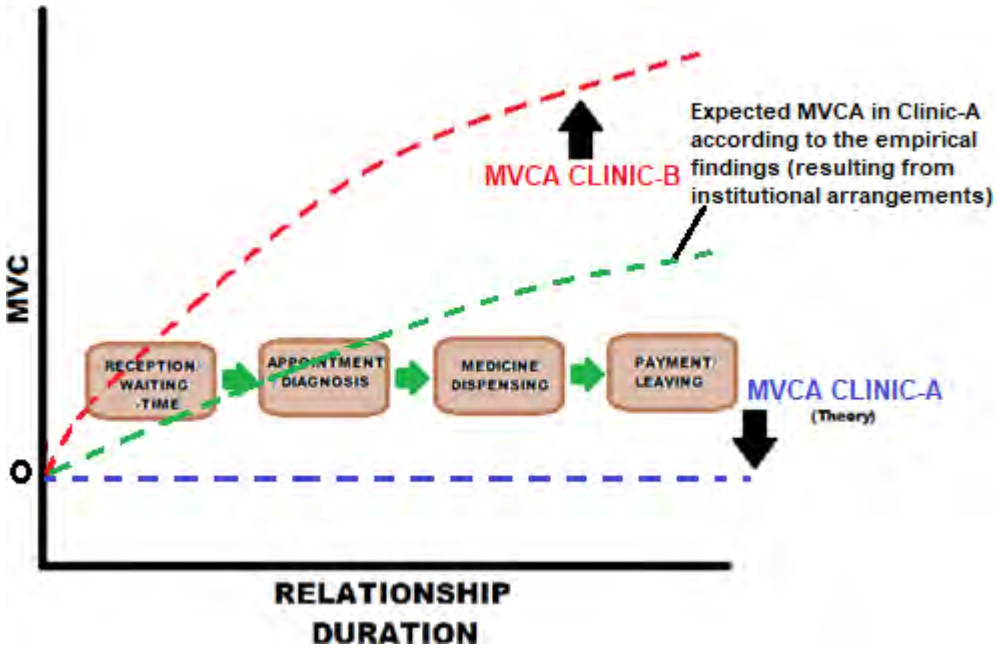


Figure 6.7: A weak comparison on MVCA

As evident from Figure 6.7, Clinic-B is seen to demonstrate higher MVCA than Clinic-A due to superior service quality, innovation, patient engagement, and high knowledge transfer. SDL theory seems to apply in this context as high socio-economic societies of the developing countries are found to show similarities to the research conducted on SDL in the developed countries (Vespestad and Clancy, 2019; Joiner and Lusch, 2019). Alternatively, the expected curve of MVCA for Clinic-A shows a higher MVC between service actors than the curve obtained from theoretical knowledge, due to the difference of value perception observed in these settings. The difference in both curves, however, does suggest the significance of SDL being an important factor to increase mutual value creation between service actors. These findings suggest that the literature on SDL is incomplete and does not take into consideration the micro and macro factors that impact its applicability in different settings. The next section is intended to discuss the implications for the SDL framework so that the path towards a more empirically sound theory of SDL could be made possible.

6.10.2 VALUE COCREATION AS A CONTINUUM FROM GDL TO SDL

Evaluating MVCA (empirically) for both healthcare clinics has strongly indicated that value cocreation may be conceived as a continuum, running from GDL to SDL, rather than two separate marketing paradigms. To understand this phenomenon better, the figure below is intended to represent how Clinic-A and Clinic-B differ from one another in their respective service strategies.

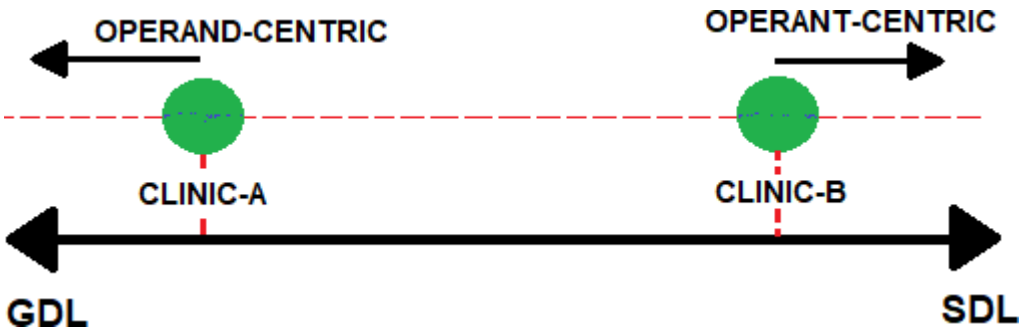


Figure 6.8: GDL & SDL Continuum

As evident from the figure above, Clinic-A is positioned on the left-hand side of the spectrum, making it closer to the GDL marketing approach. This position indicates that this organization is more operand-centric and tends to practice standardization in its service delivery structure. Clinic-B alternatively, is positioned on the right-hand side of the spectrum, indicating a more SDL-oriented organization tending towards an operant-centric resource orientation. The important understanding that comes out from this figure is that SDL and GDL service strategies are not in themselves diagrammatically opposed absolute approaches to marketing and service operations, but instead represent positions on a spectrum of pragmatic business strategies developed in response to different customer value segments and institutional contexts. These findings also clarify that Vargo and Lusch's (2004, 2008, 2015, 2016) SDL theory being completely distinct (and *superior*) market approach (to GDL) seems to be an over-exaggeration in the light of the empirical findings of this study. Moreover, organizations in the developing world are seen to adapt to the institutional

arrangements present in their respective societies to provide for the needs of their customers. Where necessary (for example Clinic-A), business enterprises choose to match their value propositions to the needs of their consumers. The end goal for healthcare firms is to create MVC by understanding what 'value' actually means to the patients, and in this way demonstrate their understanding of an axiom (Axiom 4) at the core of Vargo & Lusch's (2016) latest conceptualization of SDL: that value is truly uniquely determined by the beneficiaries.

This understanding brings us back to the study of Helle and Gronroos (2010) who proposed three dimensions of value (i.e., technical, financial, and perceptional value). The element that is found to be missing in Vargo & Lusch's conceptualization of SDL theory is that the firms can also create MVC with their customers based on the dimensions of value that are not entirely service-oriented. For example, Clinic-A is found to accumulate MVC based on a reductive strategy of a cost-effective value proposition. The findings indicate that this is an entirely valid service segmentation strategy in the eyes of its customers, even though it differs from the accommodative strategy of Clinic-B. The fact is that Clinic-A's customers cannot afford the accommodative service package provided by Clinic-B, nor do they expect it.

The findings of this study have confirmed that the GDL approach of marketing and service operations can also lead to MVC accumulation, as seen in the case of Clinic-A. Though, the gap between the MVCA trajectories for both healthcare clinics may be closer in reality than the extant SDL theory predicts. Therefore, SDL cannot be regarded as a one-size-fits-all approach, especially after evaluation from the data obtained from the healthcare sector of a developing country.

6.11 IMPLICATIONS FOR SDL FRAMEWORK

The last section discussed how the perception of value changes the expected outcomes in healthcare institutions. It was observed that SDL theory itself was not enough to justify mutual value creation taking place between service providers and service beneficiaries in developing countries. There are two major implications for the SDL framework that have come to the surface by conducting the MVC assessment in

the last section. Both of these implications stem from the value perception of the service beneficiaries and aim to improve the findings in the scope of developing countries. Detail of both implications is followed in the next two paragraphs.

The first implication for 'SDL Framework in Healthcare' is to include the impact of socio-economic factors while assessing the presence of SDL in an organization. Researchers could look at different research settings to examine socio-economic conditions and its impact on the organizations. Exploring Clinic-A and B has revealed the difference in perception of value for patients belonging to each category and an understanding has developed that warrants the need to contextualize socio-economic conditions before drawing to any conclusions. In essence, it is observed that financial value matters more to people belonging to low socio-economic areas whereas technical value is found to hold more significance for the patients living in high socio-economic societies. Understanding customer perception is very important as the whole rationale behind measuring SDL presence is to augment value cocreation between the service actors. Therefore, the researcher stresses that it is necessary to account for the socio-economic impact on service actors when measuring SDL in a developing country. Moreover, it is seen that culture has played a big role in the differences observed with Clinic-A, therefore researchers can cross-examine multiple cultural case studies that could determine the impact of SDL presence on the healthcare organizations.

The second implication for SDL Presence Framework in Healthcare is to consider that institutional arrangements present in the developing countries are quite complex. Researchers must contemplate the local culture, geographical location, and the need for the identification of specific market segments. It is observed that the patients living in developing countries adhere to social constructs and norms that are different from the developed states. The one-size-fits-all approach of SDL cannot be applied in this context and doing so jeopardizes the credibility of this research. Some examples of institutional arrangements have been previously highlighted which include, lower sharing of knowledge, gender segregation, etc. Taking the example of 'sharing of knowledge', it is seen that the SDL Healthcare framework would yield uncredible findings as low transfer of knowledge is seen to cocreate more value when contextualized to institutional arrangements of certain societies. Moreover, it appears from the empirical findings that considering the GDL approach for service provision is

equally important as the SDL approach. Examples can be taken from Clinic-A and B, where the usefulness and profitability of the GDL approach are seen to benefit both the service providers and beneficiaries.

As the implications for SDL Presence Framework have been highlighted, the author believes it is pertinent to discuss the micro, meso, and macro levels which can be implied to SDL theory based on the studies in Clinic-A and Clinic-B. The implications for SDL theory are presented in the next section.

6.12 IMPLICATIONS FOR SDL THEORY

Providing implications for the SDL theory requires recollecting the literature that has been discussed in chapter two of this thesis. The author has provided a summary for all the relevant sections (from the literature review) that were composed to discuss the SDL theory. This is followed by a comparison between case study findings and the literature on SDL theory, which leads to providing implications for the five axioms of SDL.

Section 2.1 from the literature chapter introduced 'Goods Dominant Logic' (GDL) where Vargo and Lusch (2004) presented their analogy on the change from product-focused marketing to service marketing. Foundations for SDL theory were laid on the grounds that "*the market mostly transitioned from product focus to relationship focus over the past 50 years*" (Vargo and Lusch, 2004). In contrast to this statement, the researcher found compelling evidence that not only highlighted both authors' historical limitations but also broadened the scope of this research (Tadajewski and Jones, 2020). Exploring past pieces of literature helped the author to analyze trends in service marketing and 'relation building' that existed in the market and scholarly research before the mentioned time frame. Examples, in this case, include the aspects of capitalism and service socialism, that are seen to be missing in Vargo and Lusch's periodically revised publications (Sheldon, 1913; Baker, 1957; Tadajewski and Jones, 2020). Though having some historical limitations in Vargo and Lusch's (2004) publication seems like a small error, its impact can be seen in the subsequent publications of both authors, which lack certain aspects of societal influences or in simple terms, institutional arrangements. These limitations are seen to swell in their subsequent publications where the necessity to include a diverse sample population

and research settings is completely ignored. These limitations have given birth to SDL theory which fails to understand the dynamics of healthcare markets in developing countries and the impact on SDL based on socio-economic differences. Henceforth, the first implications for SDL theory lie in the inclusion/consideration of literature published before the 50-year period mentioned. This is believed to help in building theoretical foundations that include important developments taking place towards service centricity.

Section 2.2 and ***2.3*** progressed towards discussing the role of operand resources, which are considered an important aspect of GDL. Table 2.1 of the literature review chapter, which is adapted from the study of Vargo and Lusch (2004), characterized operand resources and the perception of value that is associated with product-based marketing. After conducting explorations in both healthcare clinics, the researcher obtained empirical evidence that backs up the literature of Vargo and Lusch (2004) on operand resources and the marketing thought that defines them. Value is therefore seen to be determined by the producer and is seen to be embedded with goods i.e., exchange value.

Moving forward, ***section 2.4*** is seen to introduce the theory on SDL which is followed by ***section 2.5*** that discusses the role of operant resources, the foundational premises of SDL (FPs), and finally the introduction of the 5 axioms of SDL. Stress is seen to be given on the philosophy that service is the fundamental basis of value creation through exchange. Table 2.2 of the literature review chapter is seen to deliberate on the centrality of operant resources when viewed under the lens of SDL. The progression of SDL theory in Vargo and Lusch's (2004) article portrays a narrative that compels the reader to believe that SDL is somehow a solution to the problems existing in the current market dynamics. Readers are also given the impression that focusing on GDL is old marketing thought that needs to be substituted by SDL as the economies have progressed towards service capitalization. Therefore, the implications for SDL theory in this particular area of interest stem from the empirical findings of explored healthcare clinics (Clinic-A and Clinic-B).

As the crux of SDL theory is based on its five axioms, the researcher is going to compare all axioms individually with the empirical evidence derived from exploring both healthcare clinics. Implications for axioms are as followed:

6.12.1 IMPLICATIONS ASSOCIATED WITH THE 5 AXIOMS OF SDL

Exploring Clinic-A and Clinic-B has revealed that SDL is not a one-size-fits-all framework, but rather one end of a strategic continuum running from GDL to SDL. The subsections provided above have been designed periodically to explain how SDL theory needs to be updated to progress towards a universally accepted phenomenon. It is, therefore, necessary to compare the literature on the 5 axioms of SDL theory with the findings of healthcare clinics to draw the implications. The detail is as followed:

AXIOM 1: SERVICE IS THE FUNDAMENTAL BASIS OF EXCHANGE

The first axiom of SDL is formed after the amalgamation of the first 5 FPs of SDL by Vargo and Lusch (2004; 2015). It stresses that service is at the heart of all exchange taking place and the application of operant resources form the fundamental basis of all exchange. Findings from Clinic-A have revealed that this is not the case when it comes to the service actors associated with this healthcare clinic. Goods (medications) are found to be the primary basis of exchange that underpins all of Clinic-A's customer relationships. As the clinic is found to belong in a low-income society, the economy is seen to practice and follow the GDL approach of marketing. Having a deeper insight, it is found that the marketing strategy of Clinic-A is comprised of tangible offerings (low-cost treatment and medication), where the clinic keeps the GDL approach as its main marketing strategy. Interview responses from the CEO of Clinic-A pointed out that the top management considers operand resources to be the primary source of the firm's competitive advantage and the objective of this healthcare clinic is to create value propositions to earn profits. Value is found to be embedded in the medication that is prescribed to the visiting patients and the clinic acquires value in terms of profits made (operand resource). This marketing approach is seen to work in favor of Clinic-A as the ROI shared by the CEO shows an increase in business profits over time. Henceforth, the first axiom of SDL is not seen to satisfy the conditions for its applicability in such settings.

Alternatively, an exploration of Clinic-B has revealed that there is a clear indication of service being the fundamental basis of exchange. Therefore, focusing on the application of operant resources is found to be an essential basis of exchange in this

healthcare clinic. Though, it is observed that the focus of patients also lies on goods (medication) before deciding to associate with a healthcare clinic. This finding contradicts FP3 of SDL (Vargo and Lusch, 2004), which considers goods to be merely distribution mechanisms for service provision. The researcher observed a mix of operand and operant resources being utilized in Clinic-B that points towards the mutual existence of GDL and SDL being followed in the organization. For this purpose, Clinic-B is seen to focus on both, tangible and intangible offerings for the visiting patients. Interview responses from the CEO of Clinic-B pointed out that the top management considers a mix of operant and operand resources to be effective for the firm's competitive advantage. Being located in a high socio-economic area of Pakistan, Clinic-B is found to relate more with the service economies of the developed countries.

The findings from both clinics, therefore, confirm that SDL is merely one end of a strategic continuum from GDL to SDL, and either service, goods, or both could be considered as the fundamental basis of exchange, depending on the impacting factors.

AXIOM 2: VALUE IS COCREATED BY MULTIPLE ACTORS, ALWAYS INCLUDING THE BENEFICIARY

The 2nd Axiom of SDL is seen to stress the concept of value creation as essentially experimental, relational, and contextual. It pinpoints that value is always created through service exchange or resource integration (which can be direct or indirect). The most stressed point by Vargo and Lusch (2004) is based on the fact that value cannot be created by service providers alone and then delivered to the service beneficiaries. Looking at the findings from Clinic-A, it is observed that value propositions (especially financial components) are created by the service providers, based on market intelligence. Focus on competition is the biggest factor that leads to the creation of certain market dynamics in which service providers try to offer the lowest possible prices for their products/services. This strategy is seen to take cocreation aspect away from the beneficiaries (directly), who have no option but to choose from the cheapest alternatives. A sense of pre-packed value in form of goods (medication) is seen to be marketed by the service providers, which in turn is utilized by the service beneficiaries. Again, the service-centered view is not found to be inherently advantageous in such

organizations as value is seen to be more relational with the competing organizations as opposed to the service beneficiaries.

Clinic-B, however, is seen to validate the second axiom of SDL completely as the findings have shown such economies to possess similarities to the developed world. Value is found to be relational and thus seen to be cocreated by multiple actors, especially including the beneficiary. Service providers are seen to participate in the offering and creation of value (along with the beneficiaries), and the possibility to deliver value alone is not found to be working for this scenario. A high focus on the service-centered view (not entire focus) is thus found to be inherently beneficiary-oriented and relational. Such findings again validate value to be subjective for the recipient audiences and stress that 2nd axiom of SDL only applies when the conditions are favorable. Hence, SDL should not be taken as a complete theory but rather as an end of a strategic continuum.

AXIOM 3: ALL SOCIAL AND ECONOMIC ACTORS ARE RESOURCE INTEGRATORS

The third axiom of SDL is quite important for this research as it takes the focus of exploration from a micro level to meso and macro levels by the process of *zooming out* (Vargo and Lusch, 2015). This axiom stresses that actors are not separate entities from the environment and are at the effect as well as the creator of the environment. In simple words, the researchers (Vargo and Lusch, 2015) are seen to introduce the concept of a service ecosystem where the exchanges are not limited to dyads or triads but can be seen to reach bigger levels (societies/industries). As aforementioned, such exchanges are difficult to map under the light of empirical evidence as it requires a huge amount of data and analysis of complex service ecosystems (Grönroos, 2017). The practical approach for this exploration, however, has been to acquire primary data from the healthcare clinics (on the micro-level) and then compare it with the secondary data of the societies/economies to understand the impact on meso and macro levels. Vargo and Lusch (2015) have emphasized that the unit of analysis (under service ecosystem perspective) expands beyond a dyad to include actors in extended supply chains and service systems. Such expansion infers that the concept of value needs to

be re-evaluated since the influence of multiple actors is now seen to be significant. Understanding service exchanges/interactions in a multi-actor setting infer that value is created as a holistic sum of all actors involved, their underlying institutions, and gives a further in-depth understanding of how these institutions are formed and the role they execute.

In Clinic-A, the researcher observed B2P transactions (on the micro-level) that go beyond the scope of organizations and validate the influence of meso/macro factors on the way service actors interact. The element of service ecosystems does hold sense in the developing world as the actors are seen to be bound with the institutions and institutional arrangements they belong to. For example, the dyadic interaction in Clinic-A is seen to be working in a way in which the service provider generates service offerings that feed into the various activities of sales, service, operations, and support. These service offerings, as aforementioned, result from the competition surrounding Clinic-A and help to attract business customers (patients). The environment in which Clinic-A operates is seen to impact the clinic beyond the scope of a dyadic relationship and thus expands the service ecosystem beyond the levels of triads, quadrats, and so on. While these findings are somewhat theoretical, the researcher is going to recommend further research in the concluding chapter for macro and meso level empirical findings.

Alternatively, Clinic-B is seen to fit well with the theory of SDL, with the role of multiple actors demonstrating a profitable service ecosystem. The dynamics of this market are found to be different than Clinic-A in a way that the service offerings are designed with the input of beneficiaries and stakeholders instead of the competing businesses around the clinic. Suppliers, stakeholders, patients, and staff are observed to exchange knowledge and skills in Clinic-B which shows multiple level resource integration on the micro-level, and the secondary data on high socio-economic societies are seen to back a similar trend on the macro-level (running throughout the society).

AXIOM 4: VALUE IS UNIQUELY DETERMINED BY THE BENEFICIARY

Axiom 4 of SDL asserts that the meaning and implication of value can be different for each actor involved in the service exchange. In other words, value perception valid for

one service actor might not be effective for the other and only the actor experiencing the benefit of a specific service exchange can determine its true value. Findings from Clinic-A have asserted that axiom 4 of SDL is the biggest evidence of how its applicability in the low socio-economic areas of developing countries is not favorable. Taking axiom 4 theory to context, it is observed by the researcher that the value perceptions of the patients in both clinics differ from one another. As patients from Clinic-A are found to perceive value in terms of cost-effectiveness, the patients of Clinic-B are seen to find utility in the form of service quality and delivery performance. It is found that value perception of actors is not only different between developing and developed countries, but it goes into more complexity where different socio-economic societies operating within a developing country show variations in value perception to one another. A further level of complexity is seen to add to this notion when the value perception of the actors associated with Clinic-A demonstrate liking towards the GDL approach of marketing and the whole concept of SDL is seen to be inapplicable in the society. This point is quite interesting as the very own theory of Vargo and Lusch (2004) on axiom 4 is seen to refute the arguments the authors have presented in the favor of SDL. The authors are therefore seen to overlook developing societies where value perception demands goods to be the primary unit of exchange. Under such circumstances, there is no evidence provided by Vargo and Lusch (2004, 2008, 2015, 2016) that can justify the applicability of SDL and its usefulness.

Alternatively, findings from Clinic-B show more similarity to the developed countries in terms of how service actors perceive value. The theory on axiom 4 is found to be coherent with this clinic as various patients in Clinic-B were found to perceive value differently to one another. An example in this regard is taken from two interviews, where one of the patients was seen to perceive value in terms of how clean the clinic was and the second was happy by the relation-building activities in this clinic.

The understanding that has come out from this axiom is that value is indeed phenomenologically and uniquely determined by the beneficiaries. Moreover, the notion of this axiom goes beyond the theory of SDL, where the value perception of actors might be based on other marketing theories than SDL. For example, GDL or CDL marketing approaches.

AXIOM 5: VALUE COCREATION IS COORDINATED THROUGH INSTITUTIONS AND INSTITUTIONAL ARRANGEMENTS

The fifth axiom of SDL has been discussed extensively in this chapter, with the role of institutions and institutional arrangements highlighted expansively. As per the understanding of this axiom, resource integration and MVC not only takes place within an ecosystem but are also bounded by institutions and institutional arrangements, that are present in all levels of abstraction. Until 2016, the philosophy behind institutional arrangements has been regarded as cultural and social, with some researchers advocating the macro level of institutions to govern social life, meanings, and constructs (Akaka and Chandler, 2011; Vargo and Lusch, 2016). It has been discussed earlier that the early thinking on service ecosystems had a deep inclination originating from sociology (Chandler and Vargo, 2011) rather than political science or economics. This focus on sociology is the major reason why SDL is observed to lack the discussion of material resources and profit (Hietanen., 2018).

Exploring both case studies (Clinic-A and Clinic-B) in a developing country has highlighted how institutions and institutional arrangements lead to the creation of different market segments in the same business sector (healthcare). The influence of institutional arrangements in a developing state is seen to give birth to different market segments, operating within the confinement of the same country (Pakistan). It is observed that the norms, practices, beliefs, and ideologies can vary within the same country under different settings, for example, differences in socioeconomic status. In response to this scenario, the businesses are seen to constrict or allow certain actions for their survival in the respective societies (Scott, 2001). It is due to the theory on axiom 5 that the researcher has gathered new evidence on how developing countries and the different socio-economic societies within these countries contrast with the developed world. The strategies, practices, and beliefs observed in the developed countries are found to be too different for the developing world to adhere to.

It is therefore a theoretical recommendation from the researcher that the future theory on SDL should not only entail societal and cultural impacts, when analyzing the institutional implications within specific SDL contexts but also consider the segmentation of markets that is caused by the contextual elements.

Having discussed the implications for the 5 axioms of SDL, the author believes it is important to discuss the inferences for overall SDL theory. The subsections below provide implications for SDL in various aspects, as observed through the empirical findings of both case studies.

6.12.2 IS SDL A SUBSTITUTE FOR TRADITIONAL MARKETING CONCEPTS?

Although Vargo and Lusch (2004, 2008, 2015) repeatedly emphasized substituting GDL with SDL marketing thought, the evidence from both case studies proved otherwise. It is found that both marketing thoughts can prove to be beneficial for healthcare businesses and adaptation of a certain approach is entirely contingent on specific market dynamics. In essence, GDL and SDL ways of marketing can work independently and/or mutually for business organizations (at a micro level), and within different societies or countries (on meso and macro levels).

Studies have also shown that both healthcare clinics serve different healthcare markets and service delivery mechanisms are based on the specific requirements that the patients exhibit. Referring back to Clinic-A, the CEO is found to be benefitting from the GDL approach of marketing, while securing a continuous increase in revenue over the time period. Meanwhile, the service beneficiaries in Clinic-A are also found to be comfortable with the way the business is being operated and not showing compelling indicators to suggest a move from the current service delivery mechanism. It is observed that the need of this market is based on acquiring 'goods' and therefore, shifting this attention to a service-derived-delivery mechanism is a move that is not beneficial for the associated service actors. Alternatively, Clinic-B is observed to offer a mix of GDL and SDL approaches of marketing which is seen to satisfy the expectations of the patients visiting this healthcare clinic. Findings have revealed that Clinic-B patients are not entirely operant-centric and expect goods (medication) to be an important aspect of the exchange. Therefore, the need of this market drives service providers to divide the focus between internal and external competencies to achieve positive ROI. Being fully SDL-oriented is not an option for Clinic-B as the needs of service beneficiaries are seen to be jeopardized.

From the understanding of these empirical findings, it is suggested to broaden the scope of SDL theory that analyzes different healthcare setups with empirical results (not assertions). Clinic-B settings have proven to be very beneficial for this study as they confirmed the concept of ‘dynamic capabilities’ (Teece, 2018) being practiced in an empirical setting. Service providers in this clinic were seen to rely on both internal and external competencies. This brings forward an implication to SDL theory where 'internal capabilities' have proven to be as important as the significance of external competencies. Empirical evidence from Pakistani healthcare clinics has proven that SDL cannot be regarded as an absolute substitute for GDL theory. Meanwhile, the advantages of SDL can also not be ignored as MVC has been recorded to be higher for Clinic-B due to their adherence to SDL-mindedness. This brings us to the next important implication for SDL theory, where developing countries should be focused based on the differences recorded in their ways of doing business. A detail of this implication is presented in the next sub-section.

6.12.3 BROADENING THE HORIZON OF SDL THEORY TO INCLUDE DEVELOPING COUNTRIES

The researcher has already highlighted various historical and theoretical limitations in the publications from Vargo and Lusch (2008, 2015), with the major limitations arising due to insufficient variety in the sample population. The literature on SDL is found to be comprised of research that has mostly taken place in the developed countries and therefore, it fails to address the difference in business practices in the developing world. It is evident from the studied literature that numerous authors have taken Vargo and Lusch's work as a universally applicable phenomenon, where studying SDL in developing countries has been continuously ignored (Vespestad and Clancy, 2019; Vargo and Lusch, 2019; Joiner and Lusch, 2019; Osei-Frimpong et al., 2018; Beirão et al., 2017). This gap in theory development has led to the creation of a belief, where the impact of SDL is expected to yield the same results, globally. However, obtaining empirical results from two healthcare clinics in Pakistan has led to questioning the authenticity of the current theory on SDL. Findings from this developing country have

brought forward the need to broaden the variety of sample populations so that more accurate findings for SDL could be obtained.

In essence, the author's research has indicated that developing countries comprise economies that are either fully or partly running on the principles of product-based marketing. Factors like low human development index, low GDP, unequal distribution of income, and healthcare shape up the dynamics on which these societies operate. Also, developing countries are observed to be emerging mostly from agriculture or manufacturing sectors, where the service sector is not that developed. Alternatively, developed countries entail high human development indices, GDP, and healthcare, which impacts the lifestyle choices, and the way business is operated. Therefore, developed countries are seen to operate on service-based marketing. Given such differences, it is very unlikely that the same findings for SDL could be expected from both businesses. The author's research is the best example where the difference in outcomes is empirically proven for both types of countries.

Vargo and Lusch's assertion of, '*services being the heart of all exchanges'* is only found to be applicable in the developed world, therefore future studies must take developing states into context. Concludingly, it is implicated to increase the reach of SDL theory to developing countries so that further evidence of its applicability can be procured.

6.12.4 SDL THEORY SHOULD ENCOMPASS SOCIO-ECONOMIC FACTORS

One of the author's aims was to highlight the differences in healthcare provision of developed and developing countries. The researcher wanted to distinguish the high prevalence of private healthcare sectors operating in developing states as opposed to the developed ones. The prevalence of this situation highlighted the significance of 'financial value' when it comes to availing healthcare in the developing world. This aspect was seen to be missing in most of the explored literature on SDL theory. Further depth led to the exploration of two healthcare clinics operating within different socio-economic settings. Findings highlighted that the difference in socio-economic settings not only exists between developed and developing countries but is evident within the

developing states. As aforementioned, the majority of the work on SDL theory is comprised of studies taking place in the developed world. Due to such limitations, SDL theory is seen to lack analysis on its applicability where the cost of healthcare treatment is an important factor. Developing states, having lower income per capita and unequal distribution of income, have shown different needs when it comes to availing of healthcare services. Clinic-A and its associated patients have demonstrated a higher value perception for financial elements whereas service actors of Clinic-B have shown keen adherence to quality of services.

The author, after exploring both healthcare clinics, found a high prevalence of the GDL approach in low socio-economic settings and a mix of GDL and SDL approaches of marketing where socio-economic settings were found to be high. Implications for SDL theory are to recognize the difference in perception of value that arises due to the change in socio-economic dynamics.

6.12.5 BROADENING OF THE ROLE OF INSTITUTIONS TO INCLUDE DEVELOPING COUNTRIES

It is found that developing countries show many differences to the developed world in terms of institutions and institutional arrangements that are present in the respective societies. The role of culture, norms, practices, and values makes the functioning of certain societies completely different from the others. Under such conditions, the results cannot be expected to be similar based on mere assertions. Clinic-A and B have served as prime examples to show how institutional arrangements impacted the way of doing business.

The researcher was able to provide evidence that, use of axiom 5 to justify the need for SDL in the service sector can also be used to justify the efficacy of GDL or product-centricity. Moreover, the healthcare markets present in the low socio-economic societies of developing states were seen to restrict a transition to 'service focus' due to the institutional arrangements identified within the societies. Similarly, the institutional arrangements found in the high socio-economic society of Pakistan were

seen to warrant the need for both product and service centricity to mutually cocreate value.

Concluding this chapter, it has been highlighted that segmenting customers is a norm in healthcare markets of developing countries. Furthermore, value is proven to be highly contextual and subjective to the recipient audience. The author has brought forward new knowledge that opened up new avenues for refining SDL Presence Framework and overall SDL theory.

CONCLUSION

This chapter provided insight into the rationale behind customer segmentation in developing countries. Moreover, the reason behind market segmentation is discussed that is based on operand and operant-centric resource orientation of the organizations. The author compared discussed empirical evidence from the case studies which helped in identifying a separate B2P market for healthcare customers. Furthermore, the role of value and its perception was extensively discussed in context to the healthcare practices in developing countries. The chapter concluded with an emphasis on the role of institutional arrangements and value perceptions, which have been advised for the future implications for SDL theory.

CHAPTER 7 – CONCLUSIONS

INTRODUCTION

This chapter is designed to conclude the thesis by discussing all major elements of this study. An overview of case studies is followed by the reasoning as to how research objectives were fulfilled. Moreover, this chapter is intended to address the research limitations, suggestions for further research, and contributions to theory and practice.

7.1 OVERVIEW OF CASE STUDIES

This research aimed to understand how Service Dominant Logic might be applied in the healthcare empirical context. The researcher aimed to capture any lessons that might be useful for theory development and wanted to empirically contribute to the private healthcare practice in at least one of the developing countries (Pakistan). While achieving this aim, the author intended to make original contributions to SDL theory, which were carried out in a form of adapting and modifying to a practically applicable theoretical framework in healthcare. A model to identify the need of recognizing an already existing yet different market (B2P) is another original contribution the author had intended for while compiling this thesis.

Formulating the SDL presence framework in healthcare has only been made possible by adhering to a rigorous dual-stage process. In the first stage, the researcher adapted to a theoretical framework by Meghamis (2018), that was constructed to evaluate SDL presence in service-oriented organizations (B2B). The second stage of this process involved refining, modifying, and implementing the adapted theoretical framework to the needs of a healthcare market (B2P). This step involved the exploration of numerous pieces of literature that not only focused on the core foundational premises of SDL but also considered healthcare and the specific needs surrounding this sector. The scarcity of literature highlighting SDL's role in the healthcare of the developing world has been the biggest challenge the researcher had to face while compiling this thesis. To formulate a distinct theoretical framework for healthcare, the author explored areas such as patient psyche, patient satisfaction, psychological orientations,

innovation, relationship management, service orientations, and value cocreation in a healthcare environment. As the majority of the studied pieces of literature on healthcare did not consider the mutual value creation aspect, the author contributed to originality in this research by formulating a model (Table 2.5 and Table 2.6) in the literature review chapter, which compared and contrasted the differences between patients and conventional business consumers. Table 2.5 of the literature review helped the author to understand the 5 W's (what, when, where, why, and how) of how the patients varied from normal business customers and which of the mutual value creation aspects could be associated with a newly identified market (B2P).

'SDL Presence Framework in Healthcare' is thus formed to establish if the top management commitment, resource orientation, and service orientation of a healthcare organization represent significant contextual dynamics that influence its attitude to and engagement with SDL. The motive that these dynamics play lies around the determination of SDL-oriented mindset in the healthcare organizations, which in turn determines the success of service delivery mechanisms and patient satisfaction. The framework suggests how strong top management commitment, operant-centric resource orientation, and an accommodative service orientation characterize a strong SDL presence within a healthcare organization. Meanwhile, it also advocates that low management commitment, operand-centric resource orientation, and reductive service orientation lead to a weaker SDL presence within healthcare-providing institutions.

On the horizontal axis, the framework is seen to represent the dynamics that capture mutual value creation in a healthcare organization. The dynamics of service exchange in this genre categorically focus on innovation/patient involvement in the service design, transfer of knowledge, and the amount of patient engagement in the clinical services. The mutual value creation dynamics of this framework, therefore, imply that having strong innovation, high patient involvement in service design, strong knowledge transfer, and a relationship orientation based on high patient engagement with individualized relation-building efforts, yield strong mutual value creation between the service actors. Consequently, the healthcare organization is seen to have a strong SDL mindset, spreading throughout its hierarchy. Similarly, healthcare organizations demonstrating a lower commitment to the said dynamics, are implied to be lesser SDL-minded within their clinical hierarchy.

Tables 2.5 and 2.6 of the literature review chapter demonstrated identification of an already existing market that was neither identified nor taken into consideration in any of the studied pieces of literature on SDL in healthcare. These tables helped to classify how patients differed from conventional business consumers based on their psychological orientation, free will to choose between service providers, having multiple options, and their value goal achievements. Through exploring both case studies, the researcher was able to verify the said differences in the patients of both clinics, in comparison to literature reviewed on conventional business consumers. The identification helped this study in conducting an in-depth investigation into what meaning value holds for service beneficiaries of the healthcare sector.

The supervisory team and the researcher agreed that an exploratory study of two healthcare clinics would serve best to achieve the aims of this empirical research study. For this purpose, the author requested access to two healthcare clinics in different socio-economic settings within Pakistan. The CEOs of Clinic-A and Clinic-B accepted the investigation after which both clinics were decided to serve as primary units of analysis. All service actors associated with healthcare clinics were studied and segmented into different chunks to create clarity in the research. Data collection methods were chosen to follow a qualitative approach, through which the researcher would be able to conduct in-depth interviews, map the service exchange processes and practices, conduct surveys, and observe the operational procedures.

Results from both clinics demonstrated considerable variations in service exchange behaviors, service delivery mechanisms, managerial practices, and patient satisfaction indices. Having such findings provided significant insight into the contextual and value creation characteristics of service actors in both healthcare clinics. Consequently, the researcher was able to acquire enough evidence that provided a sound basis for assessing SDL presence in Clinic-A and Clinic-B. Applying ‘SDL Presence Framework in Healthcare’ to both healthcare clinics resulted in the observation of significant variations that were recorded by the author. Clinic-A was found to depict a low presence of SDL as a result of reductive service orientation, operand-centric resource orientation, and a weak top management commitment. Clinic-B, alternatively, was found to exhibit high SDL presence due to accommodative service orientation, operant-centricity, and high commitment from the top management. These variations in service exchange were then used to determine the

intensity of mutual value creation within each clinic. The results acquired from the empirical evidence showed that mutual value creation, along with the perception of 'value' was highly contextual and subjective to the recipient audiences.

7.2 FULFILLMENT OF RESEARCH OBJECTIVES

This research attempted to achieve the three research objectives which were set out in the introduction chapter. Achievement of the objectives is as followed:

7.2.1 RESEARCH OBJECTIVE 1

To apply and adapt a framework based on the interpretations from the axioms and Fundamental Premises of SDL theory – which would facilitate the evaluation of SDL by determining its presence within the healthcare organizations of Pakistan

An SDL assessment framework in healthcare was developed through a dual-stage process. This framework is presented in the Literature Review chapter of this thesis. Developing this framework included an adaptation of a framework from service-oriented organizations (B2B), which was refined and modified to assess SDL presence in the clinical settings (healthcare).

7.2.2 RESEARCH OBJECTIVE 2

To evaluate mutual value creation in different socio-economic societies of Pakistan by assessing the presence of different service relations

By choosing one healthcare clinic in an underdeveloped area (Clinic-A) and the other in a posh locality of Pakistan (Clinic-B), the researcher ensured an in-depth assessment of mutual value creation in two different socio-economic contexts. The actual evaluation of mutual value creation in both healthcare clinics followed the

analysis of contextual dynamics - mapping of service exchange activities, resource integration measures, top management's position and value creation dynamics – measuring patient engagement in service design, the intensity of knowledge transfer and patient engagement in healthcare clinics. It was conceivable to recognize the antecedents and dynamics of service exchange that contributed or constrained mutual value creation.

7.2.3 RESEARCH OBJECTIVE 3

To assess the application of SDL presence framework of healthcare in Pakistan, within the context of empirical evidence and SDL theory

As the aim of this study was to empirically contribute to the practice and theory, it was important for the author to verify SDL theory in at least one of the developing countries. By conducting a detailed analysis in the discussion section, along with the literature depicting healthcare delivery in developing countries, the researcher was able to successfully assess the authenticity and usefulness of the SDL presence framework in the private healthcare sector of Pakistan.

7.3 RESEARCH CONTRIBUTIONS (THEORY)

7.3.1 VALUE

The theory on SDL is seen to be deeply rooted in the terms; *value*, and *value cocreation*. Though Vargo and Lusch (2004) have been contributing continuously towards the enhancement of SDL theory (Vargo and Lusch, 2008, 2015, 2016, 2019), the scholars appear to exhibit a relatively unsophisticated appreciation of the centrality of the consumers and their perception of value (Tadajewski and Jones, 2020). Their theory on SDL is seen to overlook certain fundamental aspects such as; how and if value perception differs between certain economies? Is value subjective to the recipient beneficiaries? Or what factors can change/alter the perception of value to the

consumers? Not having a strong empirical backing of such questions can shake the very foundation of SDL as it has been previously stressed to be deeply rooted in the concepts of value and its cocreation.

The understanding of value emerging from Vargo and Lusch's publications (Vargo and Lusch, 2008, 2015, 2016, 2019) gives the impression that value is constant and value cocreation is a phenomenon that is homogenous to all the global economies. As the theory is tested, edited, and modified mostly in developed countries, the discussion on value perception of consumers (as a whole) is seen to follow assumptions, rather than empirical findings. Also, the theory on SDL is seen to be very strongly worded, giving the impression that the theory is relative to all audiences globally.

Hence, the foremost research contribution to theory in this thesis is the true understanding of the term ‘value' on which SDL theory is based. Through research findings, the author demonstrated how the perception of value differed in dissimilar economic settings as well as the institutional parameters of national culture. The researcher has contributed to changes that altered the perception of value such as, socio-economic differences, culture, norms, and practices have been brought to attention that not only alter customer's perception in different economies, but also within the parameters of the same country. The researcher contributed to SDL theory by providing empirical evidence to how value is perceived, proposed, and delivered in developing countries. Also, the findings from Clinic-A and Clinic-B ascertained that the 'one-size-fits-all' approach of SDL is not valid for exploring value creation in developing countries. The author has brought forward new information to SDL theory that advocates for an in-depth analysis of value perception before making any theoretical assertions. The author has developed a more empirically sound approach to operationalizing SDL theory that advocates for the in-depth analysis of value creation for making any assumptions for mutual value creation.

7.3.2 INSTITUTIONAL ARRANGEMENTS

The second most important contribution to the theory of this thesis is related to the fifth axiom of SDL. The researcher not only identified the knowledge gap present in the role of institutions and institutional arrangements in the healthcare of developing countries but also examined the impact it had on different socio-economic societies within a developing state. The researcher was able to provide evidence that the use of axiom 5 to justify the need for SDL in the service sector can also be used to justify the efficacy of GDL or product-centricity. The contribution of new knowledge suggests that healthcare markets present in the low socio-economic societies of developing states, *do not* transition to 'service focus' due to the institutional arrangements identified within the societies. Similarly, the institutional arrangements found in the high socio-economic society of Pakistan were seen to warrant the need for both product and service centricity to mutually cocreate value.

Summarizing this contribution to theory, SDL is found to show limitations with the applicability to all exchanges, in contrast to the claims of Vargo and Lush (2004, 2998, 2015). Alternatively, the institutional arrangements present in the developing states are seen to define the needs and wants of the healthcare sector that in turn are fulfilled by the healthcare clinics (based on the socio-economic settings they belong to).

7.3.3 CONTEXTUALIZATION TO HEALTHCARE

This study contributes to the theory of SDL by contextualizing it to the healthcare sector. It discusses the current trends of healthcare present in both developed and developing countries and tries to bridge the knowledge gap that is present in the healthcare delivery system of the developing states. The new knowledge contributed by this research advocate that SDL cannot be linked to different sectors with the expectations of the same results. It is found that the applicability of SDL is different in every context because the rules of the games become different. Although there are certain similarities seen between the healthcare practices of developing nations such as India, Pakistan, and Bangladesh (Angeli and Jaiswal, 2016), there is need for future research to validate if SDL findings of this research can be applied to similar

developing countries. Contextualizing SDL to healthcare has provided empirical evidence that MVC comes from both parties (dyadic relation). The role of culture, norms, practices, and challenges identified in thehealthcare sector of the developing states paves way for a clearer understanding of the dynamics that are present and must be accounted for to address the need for practical solutions. This knowledge is believed to have opened new avenues in the literature, especially within the scope of healthcare.

7.3.4 CONTEXTUALIZATION TO THE LOCATIONAL SETTINGS OFTRANSACTION

The author contributed to new knowledge by introducing the role of locational settings of the transaction, which in turn impact the relationship dynamics between service actors. Since the conception of SDL theory, a major focus of researchers seems to be on proving that the theory is a better alternative to the traditional GDL concept of marketing (Vargo and Lusch, 2004). Lack of research in the developing states is believed to be a major reason why the significance of locational settings has not been identified/highlighted in the studied literature. By exploring two healthcare clinics in Pakistan, the researcher has realized how important location settings are when it comes to the type of relationship the service actors maintain with each other. This contribution has opened new avenues through which the scope of SDL can be empirically tested in different locations and a foundation for a valid explanation for a phenomenon might be achieved.

7.3.5 IDENTIFICATION OF B2P MARKET FOR HEALTHCARE CUSTOMERS

Although there have been many pieces of literature that point out the differences between conventional business consumers and healthcare customers, the empirical testing of this marketing thought has not been empirically tested in the domains of developing states. The researcher has contributed to the theory by exploring two private healthcare clinics in a developing country and bringing forward empirical

evidence that advocates for a separate market for healthcare customers. Consideration for a separate market for patients is necessary to conduct future research of SDL in healthcare. This attention helps in highlighting the difference of needs present between both types of customers and helps to identify the bottlenecks present in the specific market of interest i.e., the B2P market.

7.4 RESEARCH CONTRIBUTIONS (PRACTICE)

This research was conducted with the aim to contribute to healthcare practice in developing countries. The empirical evidence obtained from this exploration contributes to practice on both micro and macro level.

7.4.1 CONTRIBUTION TO PRIVATE HEALTHCARE CLINICS IN PAKISTAN

On a micro level, this research provides general practitioners with a framework to capture service exchange activities in healthcare clinics. SDL framework is seen to act as a template for service providers to improve, review and evolve their service delivery mechanism so that mutual value creation between the service actors could occur. Implementing changes in the healthcare clinics based on self-evaluation of SDL presence gives practitioners a tool that not only helps to improve the business goals but also allows patients to be more proactive in the overall service design. If implemented properly, the research contribution can help in reducing patient dissatisfaction and consequently, securing more customer retention.

7.4.2 CONTRIBUTION TO PRACTICE ON THE INTERNATIONAL LEVEL

This research tends to address one of the chief agendas of WHO to reduce the healthcare crisis in developing countries. The focus on healthcare clinics is beneficial for developing countries in terms of generating knowledge for their unsatisfactory healthcare situations (patient dissatisfaction) and highlighting the currently existing bottlenecks in their service delivery. Also, this research is aimed to reduce patient dissatisfaction in a way that would help the general population of Pakistan, which is

currently deprived of quality healthcare (in the majority of cases). This research provides an opportunity for the National Health Services (NHS) of Pakistan to implement regulations that can improve healthcare delivery across the country. As healthcare needs of the patients in Pakistan are identified according to the locational settings of transactions, this research allows NHS to implement reforms that ensure mutual value creation in the private healthcare sector. An example in this regard is taken from high socio-economic areas of Pakistan where the quality of services is seen to be the main component for value perception. Exercising laws that require a certain standard of service delivery in high socio-economic zones of Pakistan is believed to bring uniformity in the service structure and improvement in patient satisfaction. Similarly, exercising laws to cater to the 'gift culture' between pharmaceutical industries and healthcare clinics in low socio-economic areas is believed to aid in improving overall healthcare service delivery in the country.

7.5 RESEARCH LIMITATIONS

This exploration considered two healthcare clinics in a developing country for the purpose of data collection. The research strategy used to collect data was based on conducting two exploratory studies to develop a theory. Both case studies are conducted in Pakistan and are used to generalize to a theory for all developing states. The limitations incurred for including multiple developing countries in this study are believed to have originated from three main reasons. The first being 'time limitation' where the researcher did not have enough time to explore multiple developing countries within the time frame of the completion of this thesis. The second limitation is the most crucial one as the access to healthcare clinics in different countries was not possible due to the widespread of coronavirus within the research period of this study. The third limitation i.e., collecting data from multiple developing countries is associated with the cost of traveling and accommodation in different countries. The researcher was unable to bear the additional cost of conducting a 'multinational research' as the available resources were used to self-fund this thesis. More extensive research may have yielded different/additional findings privy to the topic explored. It can thus be said that the findings of this research are limited by the constraints and

context of the research strategy adopted.

This study is also limited to one case study in the high socio-economic settings and the other in low socio-economic locations. Having additional case studies in both surroundings could be used by the researcher to cross-analyze the acquired information. Limitation of access by clinic owners is the major reason why the researcher resorted to the strategy adopted in this exploration. Moving forward, the researcher felt potential bias from the employees of both healthcare clinics towards portraying a better image of the clinic they worked for. This is a cultural phenomenon that details the nature of employees working in developing countries. Although the researcher took certain measures, for example, group interviews, informal conversations, etc., this bias could have been reduced given the researcher had spent more time with the employees to overcome shyness and mistrust.

The patients interviewed in this study, though account for a large sample population, yet were majorly persuaded by clinic employees to take part in this study. This again is attributed to the shy nature of people residing in developing countries to be less proactive in being part of a research. Being influenced by clinical staff, some patients were seen to show biases towards the respective healthcare clinic. This bias could have been overcome given the researcher was provided a secluded area or room where the responses could be recorded. Given the circumstances and lack of space, this could not be made possible.

This research was conducted in both very successful and famous healthcare clinics in Pakistan. Though the researcher took all possible measures to reduce the margin of error, the inclusion of more healthcare clinics might have yielded findings different from the ones obtained.

7.6 IMPLICATIONS FOR FUTURE RESEARCH

This study is believed to have opened up various avenues for further research which

can benefit both theory and practice in the healthcare context. SDL presence framework of healthcare introduced in this exploration can be useful for future research on SDL theory and mutual value creation in the healthcare sector. This framework may allow researchers to get a comparative view of SDL presence in various healthcare organizations. Moreover, multiple locational settings could be examined through the use of this framework to analyze the difference in relationship orientation between service actors, which has been highlighted by the researcher in this study. Further research of SDL in healthcare across different cultures, socio-economic societies, and countries might become extremely beneficial for the improvement of SDL theory and its application in empirical settings.

Future research using quantitative methods can take advantage of the empirical findings provided by this research. Doing so may strengthen, challenge, or improve the current knowledge that is present in the domain of SDL in healthcare. As this research is aimed to generalize to theory, the generalizations made to the sample population may also yield positive results for theory development. The identification of the B2P market can be extremely useful in any future research that aims to understand the applicability of SDL in healthcare. The use of this model would not only increase credibility to future research but will also act as a foundation for in-depth exploration of the needs of healthcare customers.

The role of 'value perception' and its significance in SDL (healthcare) has been advocated by the researcher in this study. Future research can take benefit from the new knowledge that this study provides to understand; why and how the value perception changes between developed and developing countries. Quantitative studies can help to provide statistical data which may be able to record the difference numerically and contribute to further empirical evidence.

CONCLUSION

The researcher believes that the findings presented in this study have not only led to contributions to knowledge but also to practice. This study can open up future avenues to conduct empirical studies evaluating mutual value creation and the role of SDL in

healthcare.

REFERENCES

Achrol, R. S. and Kotler, P. (1999) 'Marketing in the Network Economy.' *Journal of Marketing*, 63 pp. 146-163.

Ahmed, J. and Sheikh, B. T. (2008) 'An all time low budget for healthcare in Pakistan.' *Community Health Sciences*, 18(6) pp. 388-391.

Akaka, M. and Chandler, J. (2011) 'Roles as resources: A social roles perspective of change in value networks.' *Marketing Theory*, 11 pp. 243-260.

Akram, M. and Khan, F. (2007) 'Health Care Services and Government Spending in Pakistan.' *Pakistan Institute of Development Economics*, 02/01,

Alderson, W. (1957) *Marketing Behavior and Exective Action: A Functionalist Approach to Marketing.* Homewood: Richard D. Irwin Inc.

Aljunid, S. M. (1995) 'The Role Of Private Practitioners In A Rural District Of Malaysia And Their Interactions With Public Health Services.' *Health Policy Unit London School of Hygiene and Tropical Medicine*,

Andaleeb, S. S. (2001) 'Service Quality Perceptions and Patient Satisfaction: A Study of Hospitals in a Developing Country.' *Social Science & Medicine*, 52 pp. 1359-1370.

Anderson, J., Narus, J. and Rossum, W. (2006) 'Customer Value Propositions in Business Markets.' *Harvard Business Review*, 84(3) pp. 90-99, 149.

Anderson, J., Rungtusanatham, M., Schroeder, R. and Devaraj, S. (2007) 'A Path Analytic Model of a Theory of Quality Management Underlying the Deming Management Method.' *Decision Sciences*, 26, 06/07, pp. 637-658.

Anderson, L. and Ostrom, A. L. (2015) 'Transformative Service Research: Advancing Our Knowledge About Service and Well-Being.' *Journal of Service Research*, 18(3) pp. 243-249.

Angeli, F. and Jaiswal, A. K. (2016) 'Business Model Innovation for Inclusive Health Care Delivery at the Bottom of the Pyramid.' *Organization and Environment*, 29(4) pp. 486-507.

Anwar, M., Green, J. and Norris, P. (2012) 'Health-seeking behaviour in Pakistan: A narrative review of the existing literature.' *Public Health*, 126(6), 2012/06/01/, pp. 507-517.

Araujo, L. and Pels, J. (2015) 'Marketization and its limits.'

Arnould, E. J. and Thompson, C. J. (2005) 'Consumer Culture Theory (CCT): Twenty Years of Research.' *Journal of Consumer Research*, 31(4) pp. 868–882.

Ashill, N. J., Rod, M. and Carruthers, J. (2008) 'The Effect of Management Commitment to Service Quality on Frontline Employees' Job Attitudes, Turnover Intentions and Service Recovery Performance in a New Public Management Context.' *http://dx.doi.org/10.1080/09652540802480944*, 5 Dec 2008,

Asree, S., Zain, M. and Razalli, R. (2010) 'Influence of leadership competency and organizational culture on responsiveness and performance of firms.' *International Journal of Contemporary Hospitality Management*, 22, 06/01, pp. 500-516.

Baker, J. C. (1957) *Business Looks at its Opportunities and Responsibilities.* Management Guide to Overseas Operations: Business Looks Abroad – at its Opportunities and Responsibilities. New York, NY: McGraw-Hill .

Balarajan, Y., Selvaraj, S. and Subramanian, S. V. (2011) 'Health care and equity in India.' *The Lancet*, 377(9764)

Ballantyne, D. and Varey, R. J. (2008) 'The Service-Dominant Logic and the Future of Marketing.' *Journal of the Academy of Marketing Science*, 36 pp. 11-14.

Ballantyne, D., Williams, J. and Aitken, R. (2011) 'Introduction to service-dominant logic: From propositions to practice.' *Industrial Marketing Management*, 40(2)

Baron, S., Warnaby, G. and Hunter-Jones, P. (2014) 'Service(s) Marketing Research: Developments and Directions.' *International Journal of Management Reviews*, 16(2)

Bastiat, F. (1995) *Selected Essays on Political Economy*. Online Library of Liberty. [Online] [Accessed https://oll.libertyfund.org/titles/bastiat-selected-essays-on-political-economy

Basu, S., Andrews, J., Kishore, S., Panjabi, R. and Stuckler, D. (2012) 'Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review.' *PLoS Med*, 9(6)

Bazelon, D. L. (1969) 'Implementing the Right to Treatment.' *University of Chicago Law Review*, 36(4)

Belk, R. W. (1992) *Collecting in aconsumer society.* London: Routledge.Achrol, R. S. and Kotler, P. (1999) 'Marketing in the Network Economy.' *Journal of Marketing*, 63 pp. 146-163.

Beirão, G., Patrício, L. and Fisk, R. (2017) 'Value cocreation in service ecosystems: Investigating health care at the micro, meso, and macro levels.' *Journal of Service Management*, 28, 04/18, pp. 227-249.

Berman, J. (2013) 'Utility of a conceptual framework within doctoral study: A researcher's reflections'. Issues in Educational Research, 23 (1), 1–18.

Bititci, U., Mendibil, K., Nudurupati, S., Garengo, P. and J, T. (2004) *Performance Measurement, Organisational Culture and Management Styles.*

Bitner, M. J., Faranda, W. T., Hubbert, A. R. and Zeithaml, V. A. (2013) 'Customer contributions and roles in service delivery.' *http://dx.doi.org/10.1108/09564239710185398*, 2013-04-12,

Blocker, C. and Barrios, A. (2015) 'The Transformative Value of a Service Experience.' *Journal of Service Research*, 18, 05/01,

Blumenthal, D., Mort, E. and Edwards, J. (1995) 'The efficacy of primary care for vulnerable population groups.' *Health services research*, 30(1 Pt 2) pp. 253-273.

Borum, F. (1989) 'Book Reviews: Andrew Pettigrew (ed.): The Management of Strategic Change: 1988, Oxford: Basil Blackwell. 370 pages.' *Organization Studies*, 10(1), 1989/01/01, pp. 131-133.

Bowen, G. (2009) 'Document Analysis as a Qualitative Research Method.' *Qualitative Research Journal*. 9. 27-40. 10.3316/QRJ0902027.

Bower, M. and Garda, R. A. (1985) 'The Role of Marketing in Management.' *In McKinsey Quarterly.* Vol. 3 pp. 34-46.

Brodie, R. J., Hollebeek, L., Juric, B. and Ilic, A. (2011) 'Customer engagement: Conceptual domain, fundamental propositions, and implications for research.'

Journal of Service Research, 17(3) pp. 1-20.

Bryman, A. (2008) *Social research methods.* 3rd Edition ed., New York: Oxford University Press.

Buriro, A., Awan, J. and Lanjwani, A. (2017) 'INTERVIEW: A RESEARCH INSTRUMENT FOR SOCIAL SCIENCE RESEARCHERS.' *International Journal of Social Sciences, Humanities and Education*, 1, 11/01, pp. 1-14.

Capon, N. and Glazer, R. (1987) 'Marketing and Technology: A Strategic Coalignment.' *Journal of Marketing*, 51(3) pp. 1-14.

Chalmers, M. (1999) 'Comparing information access approaches.' *Journal of the American Society for Information Science*, 50(12)

Chandler, J. D. and Vargo, S. L. (2011) 'Contextualization and Value-in-Context: How Context Frames Exchange.' *Marketing Theory*, 11(1) pp. 35-49.

Chathoth, P., Altinay, L., Harrington, R. J., Okumus, F. and Chan, E. S. W. (2013) 'Co-production versus co-creation: A process based continuum in the hotel service context.' *International Journal of Hospitality Management*, 32, 2013/03/01/, pp. 11-20.

Christensen, C. M., Hall, T., Dillon, K. and Duncan, D. S. (2016). Know Your Customers' "Jobs to Be Done".

Cipolla, C. and Manzini, E. (2009) 'Relational Services.' *Knowledge and Policy*, 22(1) pp. 45-50.

Costello, J. and Haggart, M. (2003) *Public Health and Society.* Public Health and Society. London: Palgrave Macmillan Ltd.

Creswell, J. W. (2012) *Qualitative Inquiry and Research Design: Choosing Among Five Approaches.* SAGE Publications Inc.

Darke, P., Shanks, G. and Broadbent, M. (1998) 'Successfully completing case study research: combining rigour, relevance and pragmatism.' *Information Systems Journal*, 8(4), 1998/10/01, pp. 273-289.

Decker, F. (2019) 'The Difference Between a Physician & a Surgeon.'

Denzin , N. K. and Lincoln , Y. S. (1994) *Handbook of qualitative research.* Thousand Oaks, CA: SAGE.

Dillard, J. (2017) 'The Data Analysis Process: 5 Steps to Better Decision Making.' *Big Sky*,

Druskat, V. (2005) 'Scholarship That Works.' *Academy of Management Journal*, 48(6) pp. 952-955.

Eisenhardt, K. M. (1989) 'Building Theories from Case Study Research.' *The Academy of Management Review*, 14(4) pp. 532-550.

Elg, M., Engström, J., Witell, L., Poksinska, B. and Verma, R. (2013) 'Co-creation and learning in health-care service development.' http://dx.doi.org/10.1108/09564231211248435, 2013-04-12,

Filene, E. A. (1929) *World Prosperity and Standards of Living '. In: Proceedings of the twenty-second annual convention of Rotary international.* Dallas: Evanston : Rotary International.

Flynn, B. B., Schroeder, R. G. and Sakakibara, S. (1995) 'The Impact of Quality Management Practices on Performance and Competitive Advantage.' *Decision Sciences*, 26(5), 1995/09/01, pp. 659-691.

Flyvbjerg, B. (2006) 'Five Misunderstandings About Case-Study Research.' *Qualitative Inquiry*, 12, 04/01, pp. 219-245.

Frei, F. (2006) 'Breaking the Trade-off between Efficiency and Service.' *Harvard business review*, 84, 12/01, pp. 93-101, 156.

Freire, K. and Sangiorgy, D. (2010) 'SERVICE DESIGN & HEALTHCARE INNOVATION: from consumption to co- production and co-creation.' *In*. Lancaster University,

Fullerton, R. A. (1988) 'How Modern is Modern Marketing? Marketing's Evolution and the Myth of the "Production Era".' *Journal of Marketing*, 52(1) pp. 108-125.

Gandolf, S. (2020) *Medicine is a profession, but healthcare is a business. Healthcare Reform , Medical Marketing*. Healthcare Success

Gersick, C. (1988) 'Time and Transition in Work Teams: Toward a New Model of Group Development.' *Academy of Management Journal*, 31, 03/01,

Gittell, J. H. (2002) 'Relationships between Service Providers and Their Impact on Customers.' *Journal of Service Research*, 4(4) pp. 299-311.

Gordon, T., Booysen, F. and Mbonigaba, J. (2020) 'Socio-economic inequalities in the multiple dimensions of access to healthcare: the case of South Africa.' *BMC Public Health*, 20(1), 2020/03/04, p. 289.

Gounaris, S. and Tzempelikos, N. (2014) 'Relational key account management: Building key account management effectiveness through structural reformations and relationship management skills.' *Industrial Marketing Management*, 43(7), 2014/10/01/, pp. 1110-1123.

Grant, C. and Osanloo, A. (2014) 'Understanding, selecting, and integrating a theoretical framework in dissertation research: Creating the blueprint for your "house"'. Administrative Issues Journal: Connecting Education, Practice, and Research, 4 (2), 12–26

Gray, B. H. (1983) *The New Health Care for Profit: Doctors and Hospitals in a Competitive Environment.* An Introduction to the New Health Care for Profit. Washington (DC): National Academies Press (US).

Greenhalgh, T., Jackson, C., Shaw, S. and Janamian, T. (2016) 'Achieving Research Impact Through Co-creation in Community-Based Health Services: Literature Review and Case Study.' *The Milbank Quarterly*, 94(2), 2016/06/01, pp. 392-429.

Grönroos, C. (2011) 'Value co-creation in service logic: A critical analysis.' *Marketing Theory*, 11(3) pp. 279–301.

Grönroos, C. (2017) 'On Value and Value Creation in Service: A Management Perspective.' *Journal of Creating Value*, 3(2)

Grönroos, C. and Helle, P. (2010) 'Adopting a service logic in manufacturing: Conceptual foundation and metrics for mutual value creation.' *Journal of Service Management*, 21(5) pp. 564 – 590.

Gull. B, R. (2008) 'The Image of Nursing from Nurses' and Non-Nurses' Perspective in Pakistan.' *First Independent Nursing Journal of Pakistan*, 1(2) pp. 4-17.

Gummesson, E. (1994) 'Broadening and Specifying Relationship Marketing.' *Asia-Australia Marketing Journal*, 2(1)

Guo, J. and Li, B. (2018) 'The Application of Medical Artificial Intelligence Technology in Rural Areas of Developing Countries.' *Health Equity,* 2.1 pp. 174-181 https://www.liebertpub.com/doi/epdf/10.1089/heq.2018.0037

Gutek, B. A. (1995) *The Dynamics of Service: Reflections on the Changing Nature of Customer/Provider Interactions.* San Francisco: Jossey-Bass.

Hagel, J. and Singer, M. (1999) *Net Worth.* Boston: Harvard Business School Press.

Hardy, M. and Bryman, A. (2009) *Handbook of data analysis.*

Hardyman, W., Daunt, K. L. and Kitchener, M. (2014) 'Value Co-Creation through Patient Engagement in Health Care: A micro-level approach and research agenda.' pp. 90-107.

Hardyman, W., Daunt, K. L. and Kitchener, M. (2015) 'Value Co-Creation through Patient Engagement in Health Care: A micro-level approach and research agenda.' *Service User Involvement in Healthcare*, 17(1) pp. 90-107.

Harrington, R., Hammond, R., Ottenbacher, M., Chathoth, P. and Marlowe, B. (2019) 'From goods-service logic to a memory-dominant logic: Business logic evolution and application in hospitality.' *International Journal of Hospitality Management*, 76 pp. 252-260.

Hebdige, D. (1979) *Subculture: The Meaning of Style.* New York: Metheun and Co.

Heinonen, K., Strandvik, T. and Voima, P. (2013) 'Customer dominant value formation in service.' *European Business Review*, 25(2) pp. 104-123.

Hiatt, H. H. (1975) 'Protecting the medical commons: who is responsible?' *N Engl J Med*, 293(5) pp. 235-241.

Hietanen, J., Andéhn, M. and Bradshaw, A. (2017) 'Against the implicit politics of service-dominant logic.' *Marketing Theory*, 18(1), 2018/03/01, pp. 101-119.

Hochschild, A. (1983) *The Managed Heart: Commercialization of Human Feeling.* Berkely: University of California Press.

Homburg, C., Workman, J. and Jensen, O. (2002) 'A Configurational Perspective on Key Account Management.' *Journal of Marketing - J MARKETING*, 66, 04/01, pp. 38-60.

HSPR. (2018) *Health System Profile - Pakistan*. s. [Online] [Accessed http://apps.who.int/medicinedocs/en/d/Js17305e/

Hunt, S. D. (1983) 'General theories and the fundamental explanadaof marketing.' *Journal of Marketing*, 47 pp. 9-17.

Joiner, K. A. and Lusch, R. F. (2016) '*Evolving to a new service-dominant logic for health care . .*' *Innovation and Entrepreneurship in Health*, 3

Joiner, K. A. and Lusch, R. F. (2019) 'Evolving to a new service-dominant logic for health care.' *Innovation and Entrepreneurship in Health*, 3 pp. 25-33.

Jones, E., Richards, K., Halstead, D. and Fu, F. (2009) 'Developing a strategic framework of key account performance.' *Journal of Strategic Marketing*, 17, 06/01, pp. 221-235.

Kandampully, J., Devi, J. and Hu, H.-H. S. (2011) 'The Influence of a Hotel Firm's Quality of Service and Image and its Effect on Tourism Customer Loyalty.' *International Journal of Hospitality & Tourism Administration*, 12, 02/01, pp. 21-42.

Khowaja, K. (2009) 'Healthcare Systems and Care Delivery Systems in Pakistan.' *Journal of Nursing Administration*, 39(6) pp. 263-265.

Khursheed, M., Fayyaz, J. and Jamil, A. (2015) 'Setting Up Triage Services In The Emergency Department: Experience From A Tertiary Care Institute Of Pakistan. A Journey Toward Excellence.' *J Ayub Med Coll Abbottabad*, 27(3) pp. 737-740.

Kimbell, L. (2011) 'Rethinking Design Thinking: Part I.' *Design and Culture*, 3(3) pp. 285-306.

Kohli, A. K. and Jaworski, B. J. (1990) 'Market Orientation: The Construct, Research Propositions, and Managerial Implications.' *Journal of Marketing*, 54(2) pp. 1-18.

Kotler, P. (1997) 'Marketing management : analysis, planning, and control / Philip Kotler. - Version details.'

Kotler, P. and Keller, K. (2006) 'Marketing Management.' *Upper Saddle River, New Yersey*, 01/01,

Krisjanous, J. and Maude, R. (2014) 'Customer value co-creation within partnership models of health care: an examination of the New Zealand Midwifery Partnership Model.' *Australian Marketing Journal*, 22(3) pp. 230-237.

Kristensson, P., Matthing, J. and Johansson, N. (2008) 'Key strategies for the successful involvement of customers in the co-creation of new technology-based services.' *International Journal of Service Industry Management*, 19(4) pp. 474-491.

Kumar, D., Goel, N. K., Kalia, M., Swami, H. M. and Singh, R. (2008) 'Gap between awareness and practices regarding maternal and child health among women in an urban slum community.' *Indian J Pediatrics*, 75(5) pp. 455-458.

Lakshminarayanan, S. (2011) 'Role of government in public health: Current scenario in India and future scope.' *Journal of Family and Community Medicine*. 18 (1) pp. 26-30
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3114612/pdf/JFCM-18-26.pdf

Lanning, M. (1998) *Delivering Profitable Value: A Revolutionary Framework to Accelerate Growth, Generate Wealth and Rediscover the Heart of Business.* New York, NY: Perseus Publishing .

Laver, S. and Croxon, L. (2015) 'Narrative pedagogy with evolving case study – A transformative approach to gerontic nursing practice for undergraduate nursing students.' *Nurse Education in Practice*, 15(5), 2015/09/01/, pp. 341-344.

Layton, R. (2011) 'Towards a theory of marketing systems.' *European Journal of Marketing*, 45(1/2) pp. 259-276.

Leatherman, S., School of Public Health, U. o. N. C., London School of Economics, Minneapolis, MN, USA, Ferris, T. G., Mass General Hospital, B., MA, USA, Berwick, D., Institute for Healthcare Improvement, C., MA, USA, Omaswa, F., African Centre for Global Health and Social Transformation, K., Uganda, et al. (2018) 'The role of quality improvement in strengthening health systems in developing countries.' *International Journal for Quality in Health Care*, 22(4) pp. 237-243.

Lee, Y.-K., Nam, J.-H., Park, D.-H. and Lee, K. (2006) 'What factors influence customer-oriented prosocial behavior of customer-contact employees?' *Journal of Services Marketing*, 20, 06/01, pp. 251-264.

Leidner, R. (1991) *Fast Food, Fast Talk: Service Work and the Routinization of Everyday Life.* Berkely: University of California Press.

Lewis, M. (2019) *Operations Management: A Research Overview.*

Li, B., Lei, M. and Li, W. (2018) 'Empirical Research on Consumer Expertise and Perceived Value of Fund Investors.' *American Journal of Industrial and Business Management*, 08, 01/01, pp. 645-657.

Light, B. (2001) 'A Review of the Issues Associated with Customer Relationship Management Systems.' *In Proceedings of the 9th European Conference on Information Systems, Global Co-operation in the New Millennium*. Bled, Slovenia, ECIS 2001,

London, T. (2009) 'Making Better Investments at the Base of the Pyramid.' *Harvard business review*, 87, 05/01,

Lubeck, D. P., Litwin, M. S., Henning, J. M., Mathias, S. D., Bloor, L. and Carroll, P. R. (2000a) "An instrument to measure patient satisfaction with healthcare in an observational database: results of a validation study using data from CaPSURE.' *Am J Manag Care*, 6(1) pp. 70-76.

Lubeck, D. P., Litwin, M. S., Henning, J. M., Mathias, S. D., Bloor, L. and Carroll, P. R. (2000b) 'An instrument to measure patient satisfaction with healthcare in an observational database: results of a validation study using data from CaPSURE.' *Am J Manag Care*, 6(1), Jan, 2000/09/30, pp. 70-76.

Lusch, R. F. (2019) *The Service-Dominant Logic of Marketing.*

Lusch, R. F. and Vargo, S. L. (2006) *Service-dominant logic as a foundation for a general theory.* Armonk: ME Sharpe.

Lusch, R. F., Vargo, S. L. and O'Brien, M. (2007) 'Competing through service: Insights from service-dominant logic.' *Journal of Retailing*, 83(1) pp. 5-18.

Lynn, M., Lytle, R. and Bobek, S. (2000) 'Service orientation in transitional markets: Does it matter?' *European Journal of Marketing*, 34, 04/01, pp. 279-298.

Madhavaram, S. and Hunt, S. D. (2008) 'The service-dominant logic and a hierarchy of operant resources: developing masterful operant resources and implications for marketing strategy.' *Journal of the Academy of Marketing Science*, 36(1), 2008/03/01, pp. 67-82.

Maghamis, F. (2018) *Service dominant logic (SDL), service exchange and mutual value creation : a case study from Middle-East's telecommunication industry.* PhD Dissertation. Manchester Metropolitan University.

Mankiw, N. G. (2017) 'The Economics of Healthcare.' [Online] [Accessed

Marcinowicz, L., Chlabicz, S. and Grebowski, R. (2009) 'Patient satisfaction with healthcare provided by family

doctors: primary dimensions and an attempt at typology.' *BMC Health Services Reserch*, 9(63)

Marmot, M., Friel, S., J, H. T. A. and Taylor, S. (2008) 'Closing the gap in a generation: health equity through action on the social determinants of health.' 372(9650) pp. 1661-1669.

Mathioudakis, A., Rousalova, I., Gagnat, A. A., Saad, N. and Hardavella, G. (2016) 'How to keep good clinical records.' *In Breathe (Sheff)*. Vol. 12. pp. 369-373. http://dx.doi.org/10.1183/20734735.018016

McColl-Kennedy, J. R., Vargo, S. L., Dagger, T. S., Sweeney, J. C. and Kasteren, Y. v. (2012) 'Health Care Customer Value Cocreation Practice Styles.' *http://dx.doi.org/10.1177/1094670512442806*, 2012-05-01,

Mechanic, D. and Meyer, S. (2000) 'Concepts of trust among patients with serious illness.' *Social Science & Medicine*, 51(5)

Miller, R. W., Ligutti, L. G. and Sherwood, S. (1957) *Business Relations Abroad – Can Capitalism Survive? ', in Fenn, D. H. (ed.) Management Guide to Overseas*

Operations: Business Looks Abroad – at its Opportunities and Responsibilities. New York, NY: McGraw-Hill.

Ming-Huei, H. and Wen-Chiung, C. (2011) 'Managing Key Account Portfolios across the Process of Relationship Development: A Value Proposition–Desired Value Alignment Perspective.' *Journal of Business-to-business Marketing - J BUS-BUS MARK*, 18, 02/28, pp. 83-119.

Morgan, G. and Smircich, L. (1980) 'The Case for Qualitative Research.' *The Academy of Management Review*, 4(4) pp. 491–500.

Mustafa, S., Osama, A., Akber, R. and Johari, S. (2018) 'Promotion by Pharmaceutical Industry and Patients' Perspective in Pakistan.' *European Scientific Journal*, 14(21)

Myers, M. D. (2013) *Qualitative Research in Business & Management.* 2nd Edition ed., London: Sage Publications.

Nesta. (2015) *The NHS in 2030.*

Ng, I. C. L. and Vargo, S. L. (2018) 'Service-dominant (S-D) logic, service ecosystems and institutions: bridging

theory and practice.' *Journal of Service Management*, 29(4) pp. 518-520.

Nordgren, L. (2013) 'Value creation in health care services – developing service productivity.' http://dx.doi.org/10.1108/09513550910934529, 2013-04-11,

Normann, R. (2001) *Reframing Business: When the Map Changes the Landscape.* John Wiley and Sons.

North, D. C. (1990) *Institut ions, instit utional cha nge, and econom ic performance.* Cabmbridge: Cambridge University Press.

Nyende, H. (2018) *The role of technology in value co-creation of maternal healthcare: A service dominant logic perspective.*

Nätti, S. and Palo, T. (2012) 'Key account management in business-to-business expert organisations: An exploratory study on the implementation process.' *The Service Industries Journal*, 32, 08/01, pp. 1837-1852.

O'Donnell, O. (2007) 'Access to health care in developing countries: breaking down demand side barriers.' *Cad Saude Publica*, 23(12), Dec, 2007/12/25, pp. 2820-2834.

Ojasalo, J. (2001) 'Managing customer expectations in professional services.' *Managing Service Quality: An International Journal*, 11(3) pp. 200-212.

Osei-Frimpong, K., Wilson, A. and Iemke, F. (2018) '(PDF) Patient co-creation activities in healthcare service delivery at the micro level: The influence of online access to healthcare information.'

Patrício , L., Gustafsson, A. and Fisk, R. (2018) 'Upframing Service Design and Innovation for Research Impact.' *Journal of Service Research*, 21(1)

Payne, A. F., Storbacka, K. and Frow, P. (2008) 'Managing the co-creation of value.' *Journal of the Academic Marketing Science*, 36 pp. 83-96.

Peters, D., Garg, A., Bloom, G., Walker, D., Brieger, W. and Rahman, M. (2008) 'Poverty and Access to Health Care in Developing Countries.' *Annals of the New York Academy of Sciences*, 1136, 07/25, pp. 161-171.

Petty, R. D. (2019) 'Pain-Killer: A 19th Century Global Patent Medicine and the Beginnings of Modern Brand Marketing.' *Journal of Macromarketing*, 39(3) pp. 287-303.

Prahald, C. K. and Ramaswamy, V. (2000) 'Co-opting Customer Competence.' 2000-01-01,

Prior, D. D. and Marcos-Cuevas, J. (2016) 'Value co-destruction in interfirm relationships: The impact of actor engagement styles.' *Marketing Theory*, 16(4), 2016/12/01, pp. 533-552.

Rafaeli, A. (1989) 'When Cashiers Meet Customers: An Analysis of the Role of Supermarket Cashiers.' *Academy of Management Journal*, 32 pp. 245-273.

Ranaweera, C. (2003) 'Some moderating effects on the service quality-customer retention link.' *International journal of operations & production management*, 23(2) pp. 230-248.

Ranaweera, C. and Neely, A. (2013) 'Some moderating effects on the service quality-customer retention link.' *http://dx.doi.org/10.1108/01443570310458474*, 2013-04-11,

Randall, W., Hawkins, T., Haynie, J., Nowicki, D., Armenakis, A. and Geary, S. (2015) 'Performance-Based Logistics and Interfirm Team Processes: An Empirical Investigation.' *Journal of Business Logistics.*, 36

Ritter, T. (2014) *Driving Competitiveness and Growth through Business Model Excellence.* Frederiksberg, Denmark: CBS Competitiveness Platform.

Rittmeyer, N. (2016) 'The differences between value propositions following G-D and S-D logic: A multiple case study.' *In 8th IBA Bachelor Thesis Conference*. Enshede, The Netherlands,

Rivera-Santos, M. and Rufín, C. (2010) 'Global village vs. small town: Understanding networks at the Base of the Pyramid.' *International Business Review*, 19(2), 2010/04/01/, pp. 126-139.

Rivera-Santos, M., Rufin, C. and Karl, A. (2012) 'Bridging the institutional divide: Partnerships in subsistence markets.' *Journal of Business Research*, 65(12) pp. 1721-1727.

Rumelt, R. P. (2011) *Good Strategy/Bad Strategy: the Difference and Why it Matters.* New York, NW: Crown Business.

Ryals, L. J. and Davies, I. A. (2013) 'Where's the strategic intent in key account relationships?' *Journal of Business and Industrial Marketing*, 28(2) pp. 111-124.

Salojärvi, H., Sainio, L. M. and Tarkiainen, A. (2010) 'Organizational factors enhancing customer knowledge utilization in the management of key account relationships.' *Industrial Marketing Management*, 39(8) pp. 1395-1402.

Sanchez, R. and Heene, A. (1997) 'Reinventing strategic management: New theory and practice for competence-based competition.' *European Management Journal*, 15(3), 1997/06/01/, pp. 303-317.

Sanders, E. and Stappers, P. (2008) 'Co-creation and the new landscapes of design.' *CoDesign*, 4(1)

Saviano, M., Bassano, C. and Calabrese, M. (2010) 'A VSA-SS Approach to Healthcare Service Systems the Triple Target of Efficiency, Effectiveness and Sustainability.' *Service Science*, 2(1-2)

Schlesinger, L. A. and Heskett, J. L. (1991) 'The service-driven service company.' *Harv Bus Rev*, 69(5), Sep-Oct, 1991/08/07, pp. 71-81.

Schneider, B. and Bowen, D. (1985) 'Employee and Customer Perceptions of Service in Banks: Replication and Extension.' *Journal of Applied Psychology*, 70(3) pp. 423-433.

Schultz, D. (2016) 'Flipping the Value Creation Model.' *Journal of Creating Value*, 2(2), 2016/11/01, pp. 155-159.

Scott, W. R. (2001) *Institutions and Organizations.* Sage Publications.

Scott, W. R. (2008) *Institutions and Organizations: Ideas and Interests.* 3 ed.: Sage Publications, Los Angeles, CA.

Sears, K. (2016) Patient-oriented health care model means that the patient should be in the top of the system. In: Mukhina, N. Queens University: QIHI Journal of Healthcare Improvement and Patient Safety.

Shaikh, B. T. (2015) 'PRIVATE SECTOR IN HEALTH CARE DELIVERY: A REALITY AND A CHALLENGE IN PAKISTAN.' *27*, 2015-07-03,

Shaikh, B. T., Department of Community Health Sciences (CHS), A. K. U. K., Pakistan., Hatcher, J. and Department of Community Health Sciences (CHS), A. K. U. K., Pakistan. (2017) 'Health seeking behaviour and health service utilization in Pakistan: challenging the policy makers.' *Journal of Public Health*, 27(1) pp. 49-54.

Sheldon, A. F. (1913) 'The Philosophy and Ethics of Successful Accomplishment.' *The Rotarian*, 4(3) pp. 27 – 36.

Shostack, G. L. (1982) 'How to Design a Service.' *European Journal of Marketing*, 16(1) pp. 49-63.

Siddiqi, S., Multi-donor Support Unit, S. A. P., Islamabad, Pakistan, Multi-donor Support Unit, W. B. B., Shatirah-e-Jamhuriyat, Sector G-5/1, Islamabad, Pakistan., Hamid, S., Health Services Academy, M. o. H., Islamabad, Pakistan, Rafique, G., Health Services Academy, M. o. H., Islamabad, Pakistan, Chaudhry, S. A., et al. (2017) 'Prescription practices of public and private health care providers in Attock District of Pakistan.' *The International Journal of Health Planning and Management*, 17(1) pp. 23-40.

Skålén, P., Gummerus, J., koskull, C. V. and Magnusson, P. (2014) 'Exploring value propositions and service innovation: a service-dominant logic study.' *Journal of the Academy of Marketing Science*,

Spohrer, J., Vargo, S., Caswall, N. and Maglio, P. (2008) 'The service system is the basic abstraction of service science.' *In Proceedings of the 41st Annual Hawaii International Conference on System Science*. Hawaii, p. 104.

Stake, R. E. (1995) *The art of case study research.* Sage Publications, Inc.

Steen, M., Manschot, M. and Koning, N. (2011) 'Benefits of Co-design in Service Design Projects.' *International Journal of Design*, 5(2)

Stickdorn, M. and Schneider, J. (2010) 'This Is Service Design Thinking: Basics, Tools, Cases.' *BIS Publishers*,

Storbacka, K., Brodie, R. J, Böhman, T, Maglio, P. P, Nenonen, S. (2016) 'Actor engagement as a microfoundation for value co-creation.' *Journal of Business*, 69(8) pp. 3008 – 3017.

Storey, C. and Larbig, C. (2017) 'Absorbing Customer Knowledge: How Customer Involvement Enables Service Design Success.' *Journal of Service Research*, 21(1)

Tadajewski, M. and Jones, D. G. B. (2020) 'From goods dominant logic to service dominant logic? Service, service capitalism and service socialism.' *Marketing Theory*, pp. 1-21.

Teece, D. J. (2018) 'Business models and dynamic capabilities.' *Long Range Planning*, 51(1) pp. 40-49.

Tian, K., Sautter, P., Fischer, D., Fischbach, S., Luna-Nevarez, C., Boberg, K., Kroger, K. and Vann, R. (2014) 'Transforming health care: empowering therapeutic communities through technologyenhanced narratives.' *Journal of Consumer Research*, 41(2) pp. 237-260.

Topol, E. (2015) *The Patient Will See You Now: The Future of Medicine is in Your Hands.* New York, NY: Basic Books.

Torpie, K. (2014) 'Customer service vs. Patient care.' *Patient Experience Journal*, 1(2)

Tynan, C., McKechnie, S. and Hartley, S. (2014) 'Interpreting value in the customer service experience using customer-dominant logic.' *Journal of Marketing Management*, 30(9-10), 2014/08/01, pp. 1058-1081.

Ulwick, A. (2002) 'Turn Customer Input into Innovation.' *Harvard business review*, 80(1) pp. 91-97.

Usher, K., Mills, J., West, C., Casella, E., Dorji, P., Guo, A., Koy, V., Pego, G., et al. (2015) 'Cross-sectional survey of the disaster preparedness of nurses across the Asia–Pacific region.' *Nursing & health sciences*, 17, 08/05,

Valmohammadi, C. (2017) 'Customer relationship management: Innovation and performance.' *International Journal of Innovation Science*, 9(4) pp. 374-395.

Vargo, S. and Lusch, R. (2015) *Institutions and axioms: an extension and update of service-dominant logic.* Vol. 44.

Vargo, S. and Lusch, R. (2016) 'Service-dominant logic 2025.' *International Journal of Research in Marketing*, 34(1)

Vargo, S. L. and Lusch, R. F. (2004) 'Evolving to a New Dominant Logic for Marketing:.' *https://doi.org/10.1509/jmkg.68.1.1.24036*, 2018-10-10,

Vargo, S. L. and Lusch, R. F. (2008) 'Service-dominant logic:continuing the evolution.' *Journal of the Academy of Marketing Science*, 36(1) pp. 1-10.

Vargo, S. L. and Lusch, R. F. (2019) 'Service-dominant logic 2025 | Elsevier Enhanced Reader.'

Vargo, S. L., Maglio, P. P. and Akaka, M. A. (2008) 'On value and value co-creation: A service systems and service logic perspective.' *European Management Journal*, 26(3), 2008/06/01/, pp. 145-152.

Vespestad, M.-K. and Clancy, A. (2019) 'Service dominant logic and primary care services.' *International Journal of Quality and Service Sciences*, 11(2)

Voima, P., kristinaStrandvik, Tore. (2010) 'Exploring Customer Value Formation: A Customer Dominant Logic Perspective.' *Working Papers*, 552

Waeen, Z. A. (2007) *HEALTH CARE SYSTEM: A COMPARATIVE STUDY OF PAKISTAN AND NORWAY.*

Webster, F. E. J. (1992) 'The Changing Role of Marketing in the Corporation.' 56(4) pp. 1-17.

Weiner, B. (2009) 'A theory of organizational readiness to change.' *Implementation science : IS*, 4, 10/19, p. 67.

Weiner, B., Shortell, S. and Alexander, J. (1997) 'Promoting clinical involvement in hospital quality improvement efforts: the effects of top management, board, and physician leadership.' *Health services research*, 32(4) pp. 491-510.

WHO. (2010) 'Best practice in phlebotomy and blood collection.' 2010/03,

WHO. (2017) *Healthcare Services.* World Health Organization.

WHO. (2020) *Healthcare Services.* World Health Organization.

WHO. (2021) *Healthcare Services.* World Health Organization.

Williams, J. (2012) 'The logical structure of the service-dominant logic of marketing.' *Marketing Theory*, 12(4) pp. 471–483.

Wilson, E. and Vlosky, R. (1997) 'Partnering Relationship Activities: Building Theory from Case Study Research.' *Journal of Business Research*, 39, 05/01, pp. 59-70.

Winter, S. G. (2003) 'Understanding dynamic capabilities.' *Strategic Management Journal*, 24(10), 2003/10/01, pp. 991-995.

Wolter, J. S., Bock, D., Smith, J. S. and Cronin, J. J. (2017) 'Creating Ultimate Customer Loyalty Through Loyalty Conviction and Customer-Company Identification.' *Journal of Retailing*, 93(4), 2017/12/01/, pp. 458-476.

WorldBank. (2018) *Health expenditure, public (% of GDP) | Data*. [Online] [Accessed https://data.worldbank.org/indicator/SH.XPD.PUBL.ZS

WorldBank. (2020) *Healthcare Spending.* World Bank.

Wrzesniewski, A. and Dutton, J. (2001) 'Competent Caring in Organizations.' *In Working Paper* New York University,

Yan, Y.-H. and Kung*, C.-M. (2018) 'An Empirical Study of the Co-Creation of Values of Healthcare Consumers â€“ The Perspective of Service Dominant Logic.' *International Journal of Healthcare and Medical Sciences*, 4(5) pp. 54-59.

Yang, H., Guo, X. and Wu, T. (2015) 'Exploring the influence of the online physician service delivery process on patient satisfaction.' *Decision Support Systems*, 78 pp. 113-121.

Yi, Y. and Gong, T. (2013) 'Customer Value Co-Creation Behavior: Scale Development and Validation.' *Journal of Business Research*, 66, 09/01, pp. 1279–1284.

Yin, R. K. (1984) *Case Study Research: Design and Methods.* Beverly Hills, California.: Sage Publications.

Yoon, S.-J., Choi, D.-C. and Park, J.-W. (2007) 'Service Orientation: Its Impact on Business Performance in the Medical Service Industry.' *The Service Industries Journal*, 27(4), 2007/06/01, pp. 371-388.

Yu, E. and Sangiorgi, D. (2017) 'Service Design as an Approach to Implement the Value Cocreation Perspective in New Service Development.' *Journal of Service Research*, 21(1)

Zainuddin, N., Russell-Bennett, R. and Previte, J. (2013) 'The value of health and wellbeing: an empirical model of value creation in social marketing.' *European Journal of Marketing*, 47(9)

Zeelenberg, M. and Pieters, R. (2004) 'Beyond valence in customer dissatisfaction: A review and new findings on behavioral responses to regret and disappointment in failed services.' *Journal of Business Research*, 57(4), 2004/04/01/, pp. 445-455.

Zhang, L., Tong, H., Demirel, H. O., Duffy, V. G., Yih, Y. and Bidassie, B. (2015) 'A practical of value co-creation in healthcare services.' *Procedia Manufacturing*, 3 pp. 200-207.

Zinkhan, G. M. and Hirschheim, R. (1992) 'Truth in Marketing Theory and Research: An Alternative Perspective.' *Journal of Marketing*, 56(2), 1992/04/01, pp. 80-88.

APPENDIX A
PARTICIPANT CONSENT FORM

Date:
SAMEER ABDAL MALIK
PhD.
BUSINESS & LAW
ALL SAINTS BUSINESS SCHOOL
Manchester Metropolitan University

Manchester Metropolitan University

Consent Form

Title of Project: IMPACT OF SERVICE DELIVERY ON CUSTOMER SATISFACTION: A CASE OF PAKISTANI MEDICAL CLINICS

Name of Researcher: SAMEER ABDAL MALIK

Participant Identification Code for this project:

Please initial box

1. I confirm that I have read and understood the information sheet dated …. for the above project and have had the opportunity to ask questions about the interview procedure. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason to the named researcher. ☐
3. I understand that my responses will be sound recorded and used for analysis for this research project. ☐
4. I give/do not give permission for my interview recording to be archived as part of this research project, making it available to future researchers. ☐
5. I understand that my responses will remain anonymous. ☐
6. I agree to take part in the above research project. ☐
7. I understand that at my request a transcript of my interview can be made available to me. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

To be signed and dated in presence of the participant

Once this has been signed, you will receive a copy of your signed and dated consent form and information sheet by post.

APPENDIX B
PATIENT INTERVIEW QUESTIONS

INTERVIEW QUESTIONS (Patient-Focused)

GENTLE INTRODUCTION QUESTIONS

Q.1. How are you feeling today / What brings you to this clinic today?

Q.2. As the 'Participant Information Sheet' states, this interview is going to last for about 10-30 minutes, do I have your consent to audio record your response while you wait for your appointment with the general practitioner?

Q.3. Can you tell me about yourself briefly, starting from your age and occupation?

Q.4. How often would you have to visit a medical clinic for your health or for someone accompanying you?

SPECIFIC QUESTIONS

Q.5. Could you tell me briefly about the service expectations you might have for visiting a private medical clinic?

Q.6. What is your observation regarding the helpfulness of staff? Do you feel satisfied with the current staff behavior? Anything you would like to comment about it?

Q.7. Regarding your experience with the GP, how would you describe the communication transfer between you two? / Do you consider your GP to be a good listener and can you convey your condition the GP with ease?

Q.8. Do you believe that the GP explains you the nature of your condition, diagnosis and treatment in detail? If any ambiguity, does the GP takes time to explain everything for your complete awareness?

Q.9. If a future appointment is necessary with your GP, what procedure do you have to follow? Do you believe it is a good process?

Q.10. How do you feel about the overall management of this clinic?

Q.11. Do you feel satisfied or dis-satisfied with the services being provided to you in PPMCs?

Q.12. If you feel **satisfied** with the service delivery, can you tell me the reasons for this satisfaction?

Q.13. If you feel **dissatisfied** with the service delivery, can you tell me the reasons for this dissatisfaction?

Q.14. What measures would you suggest to improve your experience inside medical clinic?

Q.15. Does the price for obtaining medical treatment (doctor's fee) affect your choice of visiting a PPMC?

Q.16. If yes, then how much impact do you think this makes in choosing your GP?

Q.17. Are you aware of the feedback/complaints system of this medical clinic?

Q.18. If not, would you want to voice your concerns or provide your valuable feedback to the clinic?

Q.19. If yes, are you happy with the current feedback/complaints system of this medical clinic?

Q.20. What changes would you like to see in the mechanism? (for example online feedback, complains etc)

APPENDIX C
PARTICIPANT INFORMATION SHEET

Participant Information Sheet

RESEARCH TOPIC: A STUDY OF THE APPLICATION OF SDL THEORY TO THE HEALTHCARE SECTOR OF PAKISTAN

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Ask questions if anything you read is not clear or would like more information. Take time to decide whether or not to take part.

PURPOSE OF STUDY: The researcher of this study is undertaking a PhD degree and opted to examine patient satisfaction in Pakistani medical clinics. This research is purely educational and all the data associated with it.

DO I HAVE TO TAKE PART?

It is up to you to decide. We will describe the study and go through the information sheet, which we will give to you. We will then ask you to sign a consent form to show you agreed to take part. You are free to withdraw at any time, without giving a reason.
NOTE: – This will not affect the standard of care you receive.

WHAT WILL HAPPEN TO ME IF I TAKE PART?

- Your involvement will only be answering the survey/questionnaire or interview (approx.. 10 minutes)
- This research is expected to be complete in 2019

EXPENSES AND PAYMENTS?

- There are no expenses or payments associated with this research.

WHAT WILL I HAVE TO DO?

Your involvement includes;

- Answering the questions asked in the questionnaire carefully and truthfully
- Provide verbal answer or explanation (if applicable)

WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS OF TAKING PART?

As per as the scope of this research, there are no risks of taking part in this research and anonymity of your participation is kept a first priority.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

We cannot promise the study will help you but the information we get from the study will aim to help improve the treatment of people in medical clinics in the future

WHAT IF THERE IS A PROBLEM?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions (0044 744 9373377).

WILL MY TAKING PART IN THE STUDY BE KEPT CONFIDENTIAL?

All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you which leaves the hospital/surgery/university will have your name and address removed so that you cannot be recognised.

INVOLVEMENT OF THE GENERAL PRACTITIONER/FAMILY DOCTOR (GP)
Your GP has full knowledge and approved for this research to take place in this premises.
Note: This study does not pose any risk to the participants.

WHAT WILL HAPPEN IF I DON'T CARRY ON WITH THE STUDY?

If you withdraw from the study all the information and data collected from you, to date, will be destroyed and you name removed from all the study files.

WHAT WILL HAPPEN TO THE RESULTS OF THE RESEARCH STUDY?
The results of this research will be published after completion and could be made available to you upon request at (sameer.a.malik@stu.mmu.ac.uk). Information gathered from you would never be added in any report/publication unless you have given your consent.

FURTHER INFORMATION AND CONTACT DETAILS:

- For specific information about this research project the contact details of the researcher are:

Sameer Abdal Malik
Tel: 0094 744 937 3377
Email: sameer.a.malik@stu.mmu.ac.uk