Internal Social Marketing:

Lessons from the Field of Services Marketing
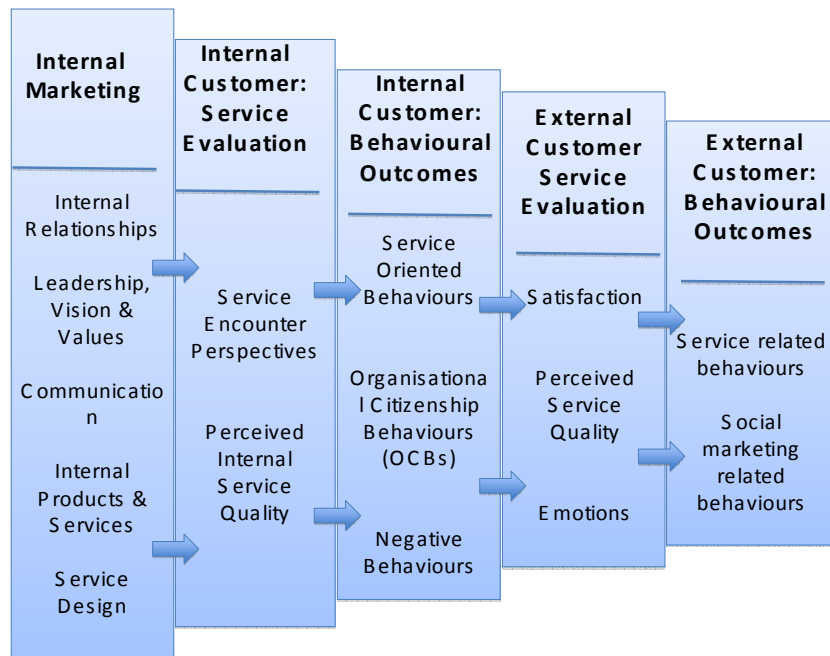
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Introduction

Services are often a key element of social marketing programmes aiming to both initiate and sustain behavioural change amongst consumers. Consequently, the quality of service, as perceived by consumers, will be fundamental to achieving behavioural goals. The impact of service experiences and evaluation on future behaviour has been widely examined in the marketing literature. The factors which consumers evaluate have been explored and relationships have been established between internal customer (employee) and external customer (consumer) satisfaction. When employees are satisfied with the service they receive, they are more likely to show care and concern for customers and 'to go the extra mile' to be helpful and responsive to their needs (Yi and Gong, 2008). A 'chain' has therefore been established (Heskett et al., 1997) between the final consumer's behaviour and the 'service' provided to employees by the organizations in which they work.

   In the 1970s marketing theorists began to focus on 'internal marketing' (IM) as an approach to achieving attitudinal and behavioural change within organizations. Originally developed within the context of services marketing, IM has been described as a philosophy for managing the organization's human resources based on a

marketing perspective (George, 1990) and has now become accepted terminology in all types of organizations (Gummesson, 2002). IM focuses on creating and delivering 'quality services' to both internal and external customers, thus achieving end-user behaviours such as repeat business and positive word-of-mouth communication. Fisk et al. (1993) state that two basic ideas underlie the IM concept: first, everyone in the organization has a customer; and, second, that internal customers must be sold on the service and happy in their jobs before they can effectively serve the final customer.

There is a vast literature with respect to consumers' service evaluation available to social marketers to aid in understanding how consumers evaluate services and how this impacts on their behaviour. Conversely, IM has been described as ambiguous and 'under-researched' (Pitt and Foreman, 1999; Wieseke et al., 2009). This chapter aims to examine how the adoption of an IM approach can achieve behavioural change amongst both internal (employee) and external customers so as to achieve social goals, particularly those related to health. The main themes are summarized in Figure 20.1. The chapter begins with an examination of the literature relating to the external customer's behaviour and how this may be determined by their service experiences and consequent evaluations. Then the focus turns to the internal customer (or employee) and examines how their behaviours (as outcomes of their own internal service experience) can impact on the final customer. Finally, the role of IM in improving internal services is examined together with conclusions and suggestions for further research.

Figure 20.2

Internal Marketing	Internal Customer: Service Evaluation	Internal Customer: Behavioural Outcomes	External Customer Service Evaluation	External Customer: Behavioural Outcomes
Internal Relationships		Service Oriented Behaviours	Satisfaction	
Leadership, Vision & Values	Service Encounter Perspectives			Service related behaviours
Communication		Organisational Citizenship Behaviours (OCBs)	Perceived Service Quality	Social marketing related behaviours
Internal Products & Services	Perceived Internal Service Quality			
Service Design		Negative Behaviours	Emotions	

Behavioural Outcomes and the External Customer: The Role of Services

Behavioural change is the ultimate goal for social marketing (Andreason, 1995; Hastings, 2007). Desired behavioural responses may include changing 'negative' behaviours such as smoking; adopting 'positive' behaviours such as increased physical activity; or sustaining 'positive' behaviours such as good dietary habits. In addition, this may include influencing, positively or negatively, the behaviour of others through word of mouth; advocacy, etc. The central role of services to effective social marketing has been illustrated in a number of studies. Phillipson et al. (2009), for example, emphasize the importance of service location and the role of the general practitioner (GP) in encouraging young people to engage with mental health issues. James and Skinner (2009) highlight the importance of the 'servicescape' (physical

environment) and service employees in changing the behaviour of homeless street drinkers. Lowry et al. (2004) describe the impact of services, in particular the attitudes and behaviour of healthcare professionals, on smoking cessation amongst pregnant women.

Services such as health care play a major role in communicating and engaging with target audiences, providing the means of distribution and creating the environment for co-production between service employees and customers. Dagger and Sweeney (2006) highlight services related to health care, fitness and weight loss; they argue that the impact of marketing on social outcomes is particularly relevant in the service context, where the interactive nature of the exchange process is also likely to influence the quality of life an individual experiences. Additionally, the service-dominant logic (S-D L) of marketing has been described as potentially foundational to social marketing (Desai, 2009; Vargo and Lusch, 2008). Three elements of S-D L – i.e. service is the fundamental basis of exchange, service is exchanged for service and that the customer is always a co-creator of value – are described as especially compatible with a social marketing approach (Vargo and Lusch, 2008).

Studies in the commercial sector have shown how customer satisfaction and service quality perceptions are directly related both to behaviours such as word-of-mouth recommendation, customer retention and complaining (Fornell, 1992; Gremler and Brown, 1999; Zahorik and Rust, 1992) and shareholder value (Anderson et al., 2004; Gruca and Rego, 2005). Positive relationships between customer satisfaction with health services and future health-related behaviour such as compliance with medical advice have been established (Hudak and Wright, 2000; Laing et al., 2002; Woodside

et al, 1989). Where consumers perceive alternatives, for example with respect to family planning services, low-quality perceptions can result in switching between service providers. Alternatively, where no perceived alternatives exist, this may result in negative behavioural change and a potential increase in 'unwanted' pregnancies (Smith, 2000). Other behavioural responses to service experiences have been described as 'citizenship' and 'dysfunctional' behaviours (Bettencourt, 1997; Yi and Gong, 2008). The former includes sharing positive experiences with other customers, assisting other customers, treating service employees in a pleasant manner, or making suggestions for the improvement of service. The latter includes critical word of mouth, disruption, or uncooperative behaviour.

One problem with relating consumers' service evaluations to behavioural outcomes is the reliance on 'behavioural intentions' (rather than actual behaviour) in many studies. Consumers' behavioral intentions, as outcomes of service evaluation, are often described as a set of multiple (behavioural and non-behavioural) responses and significant attempts have been made to identify the factors which determine such intentions (Cronin et al., 2000; Jang and Namkung, 2009; Zeithaml et al., 1996) including within a healthcare context (Choi et al., 2004; Dagger and Sweeney, 2006; 2007; Han et al., 2008). The relationship between evaluations, intended and actual behaviour, however, is complex and tenuous (Chandon et al., 2005; Morvitz, 1997). Explanatory factors may include those attributable to the research process: for example, the respondent's wish to please the researcher, express rational views or avoid complex explanations. Many of the measurement approaches used are subject to method bias, which can distort relationships between constructs (Wirtz and Bateson, 1995). Additionally, intended behaviours are subject to future developments such as

environmental change, availability of alternatives and changes in motivation of the respondent. The lack of importance accredited to situational factors in behavioural prediction is considered to be one of the factors explaining the lack of correspondence between behavioural intentions and actual behaviour (Costarelli and Colloca, 2004; Eagly and Chaiken, 1993). However, despite these limitations, researchers focus on determining how best to assess consumers' service evaluations so as to strengthen the observed relationship between evaluation and intention, thus establishing theoretical and measurement validity. The main approaches are discussed in the next section.

The External Customer's Service Evaluation

Researchers have examined a variety of approaches with respect to conceptualizing and measuring consumers' service evaluation with the aim of predicting behavioural intentions (or actual behaviour), including a substantial number of studies within a healthcare context. In particular, the role of customer satisfaction has been contrasted with that of service quality evaluation. Additionally, the role of consumer emotion in service encounters is receiving increasing attention.

Customer satisfaction and service quality evaluation

Marketing authors have emphasized the important relationship between customer satisfaction and customer loyalty, resulting in the behaviours discussed in the previous section (Hallowell, 1996; Han et al., 2008; Heskett et al., 1997: Oliver et al., 1997). However, the problems in defining 'satisfaction/dissatisfaction' have also been highlighted (Oliver, 1981). Early definitions (Anderson, 1973; Engel and Blackwell, 1982) focused on cognitive evaluations similar to those later adopted by service

quality researchers. Additionally, early conceptualizations of patient satisfaction in the medical/healthcare literature generally did not distinguish between satisfaction and attitude (Hulka et al., 1970; Roberts and Tugwell, 1987). However, Oliver (1981) argues that:

'Attitude is the consumer's relatively enduring affective orientation … while satisfaction is the emotional reaction following a disconfirmation experience which acts on the base attitude level and is consumption specific. Attitude is measured in terms more general to product or store and is less situationally oriented' (42).

The emphasis on the affective nature of satisfaction was later to constitute a key differentiating factor between customer satisfaction and service quality evaluation. Additionally, authors began to emphasize that satisfaction alone was not enough to generate customer loyalty. Instead, organizations should aim for high levels of satisfaction (Heskett et al., 1994) or to 'delight their customers' (Oliver et al., 1997).

During the 1980s, research on consumers' service evaluation began to focus on service quality. Conceptualized as a 'gap', researchers emphasized cognitive appraisals where consumers compare their expectations with their perceptions (Gronroos, 1984; Lewis and Booms, 1983; Parasuraman et al., 1988). A particular emphasis has been on identifying the dimensions, traits or factors which consumers evaluate. Two distinct dimensions, i.e. technical quality (service outcome) and functional quality (service process), are generally agreed (Dagger and Sweeney, 2006; 2007; Gronroos, 1984). Additionally, the five-dimensional classification proposed by the SERVQUAL authors (Parasuraman et al., 1985, 1988, 1991, 1994) is often quoted: i.e. tangibles (physical facilities, equipment and appearance of personnel); reliability (ability to perform the promised service dependably and accurately);

responsiveness (willingness to help customers and provide prompt service); assurance (knowledge and courtesy of employees and their ability to inspire trust and confidence; and empathy (caring, individualized attention the firm provides its customers). Health-related service quality studies have, however, produced equivocal findings that suggest fewer, or more, factors (Babakus and Boller, 1992; Babakus and Mangold, 1992; Bowers et al., 1994; Brady, 2001; Carman, 1990; Dagger and Sweeney, 2006, 2007; Headley and Miller, 1993; Peyrot et al., 1993; Reidenbach and Sandifer-Smallwood, 1990; Smith, 2000; Soliman, 1992; Sower et al., 2001; Vandamme and Leunis, 1993; Walbridge and Delene, 1993). Additionally, evidence from the patient satisfaction literature supports the likelihood of few meaningful factors underlying consumer evaluations of GP services (Hall and Dornan, 1988; Hulka and Zyzanski, 1982; Hulka et al., 1970; Pascoe, 1983; Ware and Hays, 1988; Ware et al., 1978; 1983; Zyzanski et al., 1974). These include, primarily, professional or technical competence, interpersonal qualities and convenience or accessibility of the service.

Other authors emphasize the importance of relationship quality (Crosby et al., 1990) and the role of trust and commitment in enhancing customer satisfaction and consequent behaviour (Aurier and Gilles, 2009; Bansal et al., 2004; Jones et al., 2010; Morgan and Hunt, 1994). Services may be classified as discrete or continuous (Lovelock, 1983). The former involves consumers in a 'one-off' service experience, whereas the latter involves multiple service experiences and greater potential for developing relational benefits over time (Han et al., 2008). This is particularly relevant where behavioural change requires repeat attendance: for example, GP and clinic services as well as commercial services such as gyms. Avis et al. (1997) have

described how experience of power, control and autonomy are essential in the professional–patient relationship and patients' perceptions of these will influence subsequent evaluation. Additionally, the role of 'continuity of care' has been emphasized (Smith, 2000; Ware et al., 1983; Woolley et al., 1978) and one particular aspect of 'interpersonal qualities' highlighted in many studies is that of doctor–patient communication or 'collaboration' (Barry et al., 2001; Jun et al., 1998; Woolley et al., 1978) (for a full discussion of relationship marketing, see Chapter 3 in this Handbook).

A substantial amount of work has focused on differentiating the constructs of 'consumer perceived service quality' and 'service satisfaction' in terms of patterns of antecedence, causality and nature of determinants. One debate has focused on whether perceived service quality is an antecedent of satisfaction or whether the converse is true. Early conceptualizations built on Oliver's (1981) distinction between 'satisfaction' and 'attitude' highlighted above. Parasuraman et al. (1985, 1988) argued that service quality was 'a global view' similar to attitude while satisfaction was transaction specific. Later work, however, described satisfaction as super-ordinate to service quality in the formation of consumers' intentions (Oliver, 1993; Taylor and Baker, 1994). A second stream of research has focused on the role of perceived value in explaining relationships between satisfaction and quality (Bolton and Drew, 1991; Choi et al., 2004; Cronin et al., 2000; Han et al., 2008). While yet a third approach has been to contrast the cognitive nature of service quality with the more affective nature of satisfaction (Liljander and Strandvik, 1997; Mano and Oliver, 1993; Oliver, 1993). Additionally, while some studies focus on consumers' overall evaluation of a service (Cronin and Taylor, 1992; 1994; Parasuraman et al., 1994) there is an increasing

emphasis on the 'service encounter' or 'moment of truth' in determining service-related behaviours (Bettencourt and Gwinner, 1996; Yi and Gong, 2008).

The service encounter and consumer emotion

Shostack (1985) describes any service encounter as having a potential impact on consumer behaviour: for example, those involving telephone or non-personal media such as postal and electronic interactions. Solomon et al. (1985: 100), however, define service encounters as:

'face-to-face interactions between a buyer and a seller in a service setting.'

Service encounters involve social interaction between actors (usually the consumer and the service employee) and are based on learned behaviours, or scripts (Abelson, 1981). The root cause of many provider–client interface problems is therefore attributed to the failure of participants to read from a common script (Solomon et al., 1985). Researchers (Bell et al., 2004; Bettencourt and Gwinner, 1996; Bitner et al., 1990; Verhoef et al., 2004) emphasize the dyadic nature of service interactions and the central element of role performances. Service encounter satisfaction (or dissatisfaction) is therefore conceptualized as:
'a function of the congruence between perceived behaviour expected by role players' (Solomon et al., 1985: 104).

Figure 20.2 adopts a service blueprinting approach (Fließ and Kleinaltenkamp, 2004; Shostack, 1985) to illustrate the nature of the service encounter involved in a visit to a specialist family planning clinic.

Figure 20.2
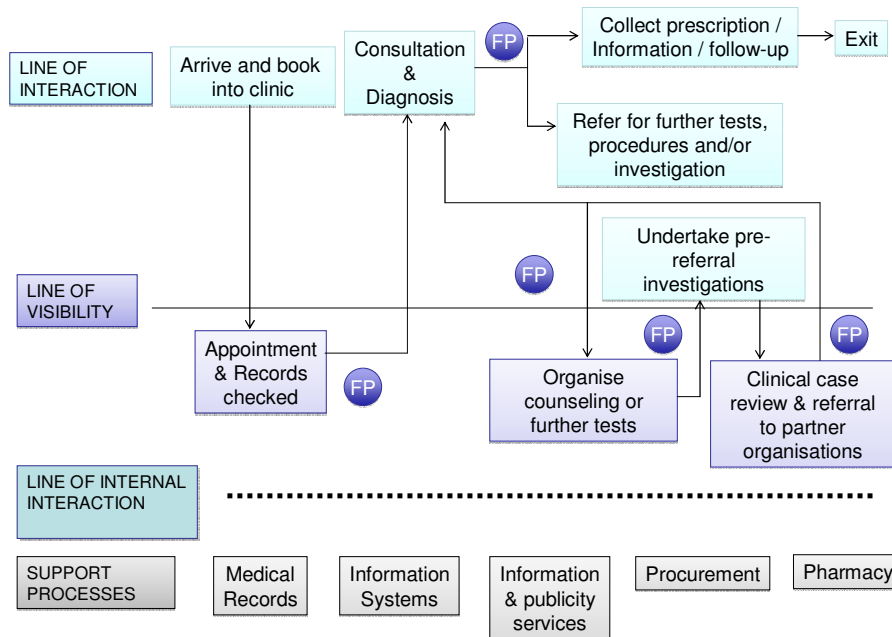
The 'line of interaction' separates the customer from the supplier action area representing the direct interactions between customer and supplier. Those interactions above the 'line of visibility' are those which the customer can identify and ultimately directly evaluate. Identifiable processes include arrival (which may also include aspects of travel such as receiving directions and advice about transport and car parking); booking in through an encounter with administrative staff; waiting before being called to the appointment; participating in the consultation and any related clinical procedure; being provided with follow-up information or onward referral information; and obtaining prescribed contraceptive supplies.

There are a number of potential fail points. Unhelpful reception staff and an unwelcoming environment may deter new customers from continuing with their visit. Inadequate staffing or over-demand for the service may result in long waiting times.

There is an inherent paradox with this type of service, as customers may prefer a specialist clinic because of the time spent with them in explaining alternatives and answering questions. Consequently, waiting times may increase. Since the clinic will not have access to the customer's medical records, apart from those specifically relevant to their clinic visits, and the consultation may not have elicited the necessary information, incorrect recommendations may be made. A visit may include consultation with both a nurse and a doctor and lack of coordination and/or availability will further increase waiting times at each stage of the process. Recommended products may not be available from the pharmacy. This may be a particular problem if, subsequently, embarrassment prevents the customer from obtaining these elsewhere. (The 'line of internal interaction' refers to the service received by internal customers and will be discussed later.)

A focus on service encounters has led many researchers to adopt a critical incident methodology (Gremler, 2004) where consumers are required to recount stories of favourable (or unfavourable) encounters and the critical incidents (or significant occurrences) which made them so. Clinic visitors will have expectations relating to the service process: employee knowledge and behaviour; the nature of the 'servicescape' (physical environment); convenience of location and waiting times; and outcome, such as availability of relevant contraceptive products and prevention of unwanted pregnancy (Smith, 2000). Critical incidents may involve unhelpful responses to customers' requests or even rude behaviour from clinic staff. Such incidents are likely to impact on service quality and satisfaction evaluations but, in addition, consumers may experience a range of negative, and/or positive, encounter-specific emotions. These may include interest, enjoyment, surprise, distress (sadness), anger, disgust, contempt, fear, shame/shyness and guilt: i.e. those which Izard (1977)

describes as fundamental and universal. Alternative schemas such as Richin's (1997) consumption-specific emotions also include discontent and worry.

The nature of consumers' emotional responses to service encounters and the subsequent impact on behavioural intentions and behaviour is receiving increasing attention (Allen et al., 1992; Arnould and Price, 1993; de Ruyter and Bloemer, 1999; Dubé and Menon, 2000; Dubé et al., 2003; Grace, 2007; Jang and Namkung, 2009; Liljander and Strandvik, 1997; Mattila and Enz, 2002; Menon and Dubé, 2000; Perugini and Bagozzi, 2001; Price et al., 1995; Smith, 2006). Indeed, Bagozzi et al. (1999) argue that:

'the implications of emotional reactions in purchase situations on complaint behaviours, word-of-mouth communication, repurchase and related actions may differ from various positive and negative emotions and be of more relevance than reactions to satisfaction or dissatisfaction, per se' (201).

Appraisal theorists argue that emotions are responses to environmental demands, circumstances and events and how these impact on the individual's prevailing goals and desires (Russell, 1991; Shaver et al., 1987; Smith and Ellsworth, 1985). A focus on emotional reactions seems particularly appropriate to an evaluation of service encounters within a social marketing context. Service encounters are purposive, task- and goal-oriented acting as social mechanisms for delivering desired outcomes (Bitner et al., 1990). Desired outcomes, or goals, include those which may substantially change the individual's quality of life, and which may include fighting addiction, as in the case of smoking cessation. Definitions which focus on negative valence highlight emotions as being 'unconscious responses to goals which are thwarted/unrealized'

(Shaver et al., 1987) and highlight that the salience of goals will further generate negative emotions such as anger or sadness (Watson and Spence, 2007). Encounters may also provoke embarrassment resulting from employee criticism and perceived violations of privacy resulting in anger and humiliation for the consumer (Grace, 2007).

A mediating factor impacting on consumers' encounter-specific emotions and subsequent behaviour is that of attribution (or agency): i.e. whether the negative (or positive) experience is attributed to self, other or the situation (Weiner, 1985, 2000). The role of attribution has been examined extensively in the marketing literature as a determinant of consumer-perceived service quality and service satisfaction evaluation (Bitner et al., 1990; Smith and Bolton, 1999). Anger, for example, is an emotion attributed to some 'other' responsibility and control, whereas guilt is associated with high levels of self-responsibility/control (Smith and Ellsworth, 1985). Both self and 'other' attributions are relevant for emotions of embarrassment (Crozier and Metts, 1994; Verbeke and Bagozzi, 2003).

The potential for employee behaviour to differ from that expected by the consumer is considerable and will impact negatively (or positively) on service evaluation. The next section considers the service encounter from the perspective of the internal customer or (employee).

The Internal Customer: Employee Behaviour and Service Evaluation

In comparison to the substantial literature examining the external customer's evaluation of services, relatively few marketing studies focus on the internal customer or employee. However, a number of authors have assessed the impact of employee behaviour on consumers' service evaluation (Kelley and Hoffman, 1997; Menon and

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Dubé, 2000; Yi and Gong, 2008); compared employees' and consumers' evaluations of service encounters (Bitner et al., 1994; Chung-Herrera et al., 2004; Mattila and Enz, 2002); and examined the main requirements of service employees relating to internal service quality (Hui et al., 2004; San Martín, 2008; Singh, 2000). The main elements are illustrated in the second and third columns of Figure 20.1 and are discussed below.

Employee service behaviours

Consumers may encounter a wide range of organizational employees as they attempt to adopt/maintain pro-social behaviours (as illustrated in Figure 20.2). These may include administrative staff, health professionals and others. Employees' service-oriented role and script behaviours are often dictated by external agencies such as professional standards and organizational rules and procedures. These typically form the basis of formal training programmes. In addition, the importance of organizational citizenship behaviour (OCB) has been emphasized: i.e. behaviour that is beneficial for an organization but falls outside formal role requirements (Podsakoff et al., 2000). Bettencourt et al. (2001) describe service-oriented OCBs as citizenship behaviours typically performed by customer contact employees and directed at the customer. These often involve providing help or assistance above and beyond the normal role behaviours expected of employees. Rafaeli et al. (2008), for example, describe such behaviours as including anticipating customer requests, offering explanations/justifications, educating customers, providing emotional support and offering personalized information.

Direct links have been established between service-oriented OCBs and customer satisfaction/service quality evaluation (Kelley and Hoffman, 1997; Morrison, 1996; Rafaeli et al., 2008) and behaviours such as word of mouth and repurchase (Netemeyer and Maxham III, 2007; Payne and Webber, 2006; Schneider et al., 2005; Yi and Gong, 2008), although some studies have failed to find direct effects (Castro et al., 2004). A tension exists, however, between those who emphasize the need to standardize and reward (at least some) role-prescribed behaviour adhering to role scripts and carrying out management's specifications (Van Dolen et al., 2004; Zeithaml et al., 1988) and those who advocate the need to respond to consumers' demands for adaptability requiring employee judgement and flexibility (Bettencourt and Gwinner, 1996; Kiely, 2005). Bitner et al. (1990), for example, identified four types of employee behaviour which would leave the consumer with a memorable, dissatisfying (or satisfying) service encounter: responses to service delivery failure; responses to customer needs and requests; and unprompted and unsolicited actions.

A second tension exists between those authors who highlight the positive aspects of 'authenticity' in staff behaviour (Price et al., 1995; Winsted, 2000) and those who emphasize the problems, for example, when employees engage in 'mimetic' rather than 'complementary' behaviour, such as when responding to customer anger (Menon and Dubé, 2000). Yi and Gong (2008) have examined the impact of 'employee dysfunctional behaviours' (EDBs), i.e. behaviours that harm organizations and/or their members. Such behaviours, including employees purposefully working slowly or being nasty or rude, were directly related to customer dissatisfaction and customer deviant behaviours (CDBs). Even where service employees intend to provide good service this may not be interpreted as such by the final consumer. Guiry (1992)

describes how overzealous service employees may adopt roles of 'dominance' where their attempts to be friendly or helpful may be considered intrusive and inappropriate by consumers. Such behaviour may be due to personality traits, lack of specific role awareness or training and/or lack of understanding of customers.

The internal customer: Service evaluation

Service employees potentially have an important role in providing insight into customers' service requirements as well as adapting the service to meet those requirements. However, while some studies have found a high level of congruence between customer and employee perceptions of service (Chung and Schneider, 2002; Schneider and Bowen, 1985), others have found substantial differences (Bitner et al., 1994; Mohr and Bitner, 1991), including between health professionals and their patients (Brown and Schwartz, 1989). Employees' evaluations of their own performance can differ markedly from those of customers (Mattila and Enz, 2002), and supervisor, rather than employee, ratings of service encounters have been shown to be more predictive of consequent customer behaviour (Netemeyer and Maxham III, 2007). Bitner et al. (1994) describe how role and script theory, combined with the routine nature of many service encounters, suggests that customers and employees are likely to share a common perspective. However, when roles are less defined and participants are unfamiliar with expected behaviours, such as a young person's first visit to a smoking cessation or sexual health clinic, possibly combined with inexperienced staff, the potential for negative service encounters is enhanced. There are also differences with respect to attribution. Employees have attributed their inability to satisfy customers to the constraints of the service delivery process, organizational policy and procedures, and sometimes to the misbehaviour of the

customers themselves. Conversely, satisfactory encounters are attributed to the employee's own ability and willingness to adjust. Customers are, however, more likely to blame employees (Bitner et al., 1994; Chung-Herrera et al., 2004).

Prior research has established a positive relationship between employee satisfaction and customer satisfaction with services (Crosby et al., 1990; Heskett et. al, 1994; 1997; Homburg and Stock, 2004, 2005; Hui et al., 2004; Payne and Webber, 2006). A face-to-face working environment is demanding for contact personnel whose main reward may be professional satisfaction, which has to be maintained at a high level to keep them motivated (Chandon et al., 1997). Front-line staff rely on the quality of service they receive from others and the competencies of co-workers to deliver high-quality service (Schneider et al., 2000). Solomon et al. (1985) highlight how role and script theory suggest a 'dramaturgical metaphor' involving 'front-stage' and 'back-stage' employees. In Figure 20.2 the 'line of internal interaction' distinguishes between front-stage and back-stage activities required to provide high- quality clinic services. This is the separation between the consultation and related processes and support activities. Internal customer relationship requirements comprise administrative functions such as organizing appointments and providing accurate customer information including medical records and results of recent tests; accurate and timely laboratory processing services; and procurement services, e.g. information leaflets and contraceptive supplies. Poor internal service quality will result in dissatisfaction, poor perceptions of quality and negative emotions, which may lead to negative attitudes and behaviours towards external customers (Bettencourt and Brown, 2003) as well as impacting on staff retention. A number of factors in particular have been highlighted to impact on employee trust, commitment and

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cooperation, directly resulting in a widening of the service performance gap (Chenet et al., 1999). These factors are role conflict and ambiguity; self-efficacy and perceived control.

Role conflict and role ambiguity

Front-line service employees fulfil a boundary-spanning role between consumers and the organization (Bitner et al., 1994; Chung and Schneider, 2002; Chung-Herrera et al., 2004). Consequently, employees may experience role conflict (an incongruity within the expectations associated with a role and which can include role overload; Singh, 2000). The problems experienced by employees, who are required to adhere to company policies, rules and regulations while simultaneously providing high standards of customer service, are well documented (Babin and Boles, 1998; Bitner et al., 1990, 1994; Chung and Schneider, 2002; Hartline and Ferrell, 1996; Hartline et al., 2000; Hui et al., 2004). Schneider and Bowen (1985), for example, found that employees experienced role stress, job dissatisfaction and frustration over being unable to give good service because of differences between their own and managements' perceptions of how services should be delivered. They also expressed intentions to change jobs. In addition, role ambiguity (the degree to which information is lacking about role expectations and effective performance of a role) may result from poor communication and performance measurement systems. Role ambiguity maintains a negative relationship with employee job (and life) satisfaction (Babin and Boles, 1998; Hui et al., 2004; Schneider et al., 1980) and is exacerbated by role conflict. Conversely, positive relationships have been identified between employee role clarity and internal customer perceived service quality, perceived external service quality and job satisfaction (Mukherjee and Malhotra, 2006).

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Self-efficacy

Central to the social cognitive theory of human behaviour are beliefs of self-efficacy, i.e.

'beliefs in one's capabilities to organize and execute the courses of action required to produce given attainments' (Bandura,1997: 3).

Relevant at the individual and collective (team and organizational) level, efficacy beliefs influence choices and courses of action (Hostager et al., 1998). Service quality studies have identified factors which impact on employees' self-efficacy beliefs. Role ambiguity maintains a negative relationship with self-efficacy. However, role conflict can have a positive effect as people search for, and find, successful ways to cope (Bandura, 1986; Hartline and Ferrell, 1996). Research supports the view that self-efficacy beliefs mediate the effect of skills or other self-beliefs on subsequent performance (Pajares, 1997).

Perceived control

Efficacy beliefs are closely related to perceived control and autonomy (Bell and Menguc, 2002). Singh (2000) describes task control, which is 'the perception of latitude and authority in dealing with job-related tasks and control over decisions that affect those tasks' (20), as a powerful resource to aid front-line service employees to cope with role tension. Service employees consider that their lack of knowledge with respect to systems and constraints and lack of authority to do anything can result in a failure to provide a satisfactory service to customers (Bitner et al., 1994). The

relationship between employee empowerment (an often contentious concept) and improved customer service has been highlighted by a number of authors (Bell and Menguc, 2002; Hartline et al., 2000; Morrison, 1996). The level of perceived control also has important direct effects on perceived role conflict and increases organizational commitment (Hartline et al., 2000; Singh, 2000; Zeithaml et al., 1986).

There is evidence therefore as to the requirements of internal customers if they are to provide quality services to external customers. Furthermore, a growing amount of research has begun to establish relationships between internal and external service-related behaviours. The next section addresses the ways in which organizations can influence employee behaviour through the adoption of an IM approach. The main points are illustrated in the first column of Figure 20.1.

The Role of Internal Marketing

Internal marketing was first introduced into the services marketing literature in the 1970s (Berry et al., 1976), yet few studies have directly related the concept to the external customer's service satisfaction/perceived service quality (for exceptions, see Bell et al., 2004; Mukherjee and Malhotra, 2006). More surprising is the relatively sparse attention given to the impact of IM on employees/internal customers (here exceptions include Ahmed et al., 2003; Bell et al., 2004; Mukherjee and Malhotra, 2006; San Martín, 2008). A few case studies have highlighted the potential for an IM approach within a healthcare context: for example, in improving collaboration between internal medical professionals so as to improve services for external customers (Gombeski et al., 1992) providing the basis for internal coordination and

communication prior to developing an external marketing campaign for geriatric services (Thomas et al., 1991); and Lee et al. (1991) describe an IM programme aimed at encouraging health service employees to communicate with external customers with the aim of increasing take-up of services.

At one level, IM involves combining marketing and human resource management approaches and techniques (George, 1990; Gronroos, 1990), including learning and competence building (Chaston, 2000). Dunne and Barnes (2000) describe how an IM programme should create four highly related ingredients: employee motivation; job satisfaction; job involvement; and organizational commitment. Morrison (1996) links human resource management to improved service quality, highlighting that an IM approach focuses on the importance of interactions not only between front-line employees and customers but also between employees themselves through improved OCBs. A major aim of IM is to develop an internal customer service orientation within the organization. Consequently, the concept of 'internal customers' and the development of internal relationships are central.

Internal customer relationships

The relational element of IM has been emphasized (Ballantyne et al., 1995; Bell et al., 2004; Gilmore and Carson, 1995; San Martín, 2008). Gummesson (2002: 189) states:

'the notion of the internal customer brings customer –supplier relationships into the company It requires employees to see other employees as customers who receive deliveries of products, services, documents, messages and decisions…'

Internal relationship quality has a positive effect on worker motivation (Bell et al., 2004). Organizations that value teamwork, cohesion and employee involvement achieve higher levels of patient satisfaction (Gregory et al., 2009). Zeithaml et al. (1988) emphasize the role of teamwork in closing the service performance gap. <t>Specific variables include the extent to which: employees view other employees as customers; contact personnel feel upper-level managers genuinely care for them; contact personnel feel they are cooperating (rather than competing) with others in the organization; and employees feel personally involved and committed. Team support provides help with difficult service encounters and is an important means of providing training. Cooperation and support from co-workers leads to role clarity, which in turn influences job satisfaction and organizational commitment (Mukherjee and Malhotra, 2006).

Trust is a key element of relationship marketing approaches, whether these are focused on external or internal relationships. Authors have emphasized the role of trust in internal relationship building (Bowen and Lawler, 1992), as an important antecedent of employee cooperation and commitment (Chenet et al., 1999) and as a determinant of the propensity to engage in OCBs (Morrison, 1996). The role of OCBs, such as 'informal helping', in building internal relationships and enhancing external service quality was discussed earlier. A wide range of vertical and horizontal relationships may be established between teams, co-workers and managers. Additionally, many health services are provided by networks, or partnerships, of cooperating agencies. Fang et al. (2008) describe how managing and building trust at multiple levels is critical to the success of inter-organizational marketing collaborations.

The role of leadership: Vision and values

The crucial role of leadership in building trust relationships and developing an organizational culture and climate reflecting a commitment to high levels of service quality is well recognized (Berry, 1995; Berry and Parasuraman, 1992; Berry et al., 1976; George, 1990; Grönroos, 1990; Schneider et al., 2005). Organizational values play a central role in internal marketing theory (Ahmed and Rafiq, 2002; Gummesson, 1987; Varey and Lewis, 1999) and practice (Foreman and Money, 1995) and are the basis of culture (Schein, 1985). Organizational culture and climate are critical determinants of an organization's ability to deliver superior service and quality to customers (Gregory et al., 2009; Payne and Webber, 2006; Schneider et al., 1998, 2005).

Wieseke et al. (2009) argue that it is the role of leaders, especially middle managers, in building organizational identification (OI) that lays the foundation for internal marketing. OI can involve customers as well as employees and refers to a sense of belonging to an organization based on positive feelings and a shared vision and values. Organizational support and OI are key factors in encouraging customer-oriented behaviours that fall outside formal role requirements (Bell and Menguc, 2002). Important roles for leaders also include providing clarity of direction and thus lowering role conflict and ambiguity; increasing employee self-efficacy beliefs through providing training and performance feedback; and increasing employee-perceived control through enhanced job autonomy (Bowen and Lawler, 1992; Hartline et al., 2000; Morrison, 1996; Wieseke et al., 2009) with the overall objective of improving both internal and external customers' perceptions of service quality.

Communication

Effective service leadership continually communicates a commitment to high levels of service quality. Information gathering, communication and responding to employee feedback have been highlighted as key elements of an IM approach (Lings and Greenley, 2005). Communication and feedback are essential in clarifying goals, expectations and levels of performance required and achieved (Mukherjee and Malhotra, 2006; Zeithaml et al., 1988). Lack of communication was highlighted earlier as a source of employee dissatisfaction directly linked to poor service delivery (Bitner et al., 2004). In addition to requiring relevant information to pass on to customers, communication plays a vital role in building trust relationships with both employees (Rothenberg, 2003) and customers (Crosby et al., 1990; Morgan and Hunt, 1994).

Internal products and services

Central to IM is the development and delivery of 'internal products and services', including practices, plans, structure, vision, mission and values (Thomson, 1990), new performance measures, new ways of working, services and training courses and the job itself (Rafiq and Ahmed, 1993).

A number of these 'products' have already been discussed. Others which are highlighted in relation to service quality are rewards, performance measures and training.

A service climate signals to employees that service quality behaviours are rewarded (Schneider et al., 1998) and the role of rewards in encouraging service-related behaviours and reducing role conflict has been established (Chung and Schneider, 2002; Morrison, 1996). An appreciation of exchange theory and equity theory are fundamental to an understanding of the service–performance gap and the relationships

between employee trust, commitment and cooperation (Chenet et al., 1999). Rewards may include a range of intrinsic and extrinsic factors which can motivate employees. Varey and Lewis (1999) describe how IM's focus on social values provides for a richer range of exchanges, both economic and non-economic. However, a rewards system relies on establishing clear performance standards/indicators for subsequent review. Such a system should be seen as fair and equitable as well as providing role clarification (Singh, 2000). One challenge, however, which has been highlighted previously, is that of how to encourage OCBs that are outside formal roles such that it is difficult to formally specify or reward them (Morrison, 1996; Yi and Gong, 2008).

Training, development and other forms of knowledge creation and sharing have a crucial role in reducing role ambiguity, increasing self-efficacy, building relationships and reducing perceived barriers to new behaviours (Schneider and Bowen, 1985; Zeithaml et al., 1990).

Training (including development and education) performs a number of essential functions in the delivery of high-quality services and is typically a core element of an IM approach (Berry and Parasuraman, 1992; Foreman and Money, 1995; Grönroos, 1990). First, the need for employees to understand customers has been highlighted (Bitner et al., 2004; Mattila and Enz, 2002). Lowry et al. (2004) provide an illustration of how involvement in training through role play helped health professionals to understand the feelings of pregnant women smokers. These related to both their negative service experiences, where they felt health professionals 'nagged' and 'preached' rather than offered support, and the meaning of the smoking behaviour itself in the lives of the target audience. This approach was evaluated highly by participants and proved to be effective in the intervention. Second, training is required to develop the requisite skills, or competencies, for providing excellent service

(Ahmed et al., 2003; Bell and Menguc, 2002; Bettencourt and Gwinner, 1996; Payne and Webber, 2006). Mattila and Enz (2002), for example, emphasize the need for staff training in recognizing appropriate behavioural responses to consumer emotions, including anger management and emotional control techniques. Third, customer-oriented training helps to develop supportive internal relationships (Bell et al., 2004) and will enhance the level of social interaction between leaders and followers (Wieseke et al., 2009). Finally, continual training and development will play a part in establishing a social exchange relationship and, hence, a basis for future OCBs (Morrison, 1996). The final section considers the role of service design in providing the 'prerequisites' for both internal and external service quality.

Service design

Employees blame poorly designed procedures and systems for causing negative service encounters that lead to both internal and external customer dissatisfaction (Bell et al., 2004; Bitner et al., 1994). The quality of the service encounter has been described as a function of the quality of the service design (Shostack, 1984; Zeithaml et.al., 2006). The service design literature offers additional tools, techniques and insights which are rarely addressed in discussions of IM. The design process creates the environment where internal (front- stage and back-stage) and external customers interact to co-produce the service.

A number of service design models focus on the service encounter. These include service blueprinting (Fließ and Kleinaltenkamp, 2004; Shostack, 1984), a design approach illustrated in Figure 20.2. Other micro models include quality function deployment (QFD) (Chan and Wu, 2002; Stuart and Tax, 1996), which has been applied within a range of public sector services including health (Dijkstra and van der

Bij, 2002; Katz, 2004; Lim and Tang, 2000). QFD establishes relationships between resource allocation decisions, customer satisfaction and competitive position and is driven by the 'voice of the customer' at all stages of the process. Such models can play an important role in facilitating coordination and communication, highlighting interrelationships and creating a common quality focus. The visual display of a substantial amount of information can aid in understanding between teams and functions and illustrates how the various organizational activities link so as to provide a customer (internal and external) focused service.

Edvardsson and Olsson (1996) describe the need to establish essential prerequisites, including customer insight and effective design of customer interfaces; staff needs, skills and knowledge, including training and development requirements; physical facilities, technology and location; and systems, structures and processes, including those for communications, rewards and performance measurement. Here there are clear parallels with IM. Additionally, the need for effective leadership at all levels and between organizational functions and teams is emphasized (Johne and Harbone, 2003). Involving service employees in the design and development of services can ensure a higher level of job satisfaction and commitment (Zeithaml et al., 2006); however, this is often not the case. Research indicates a limited role for either external or internal customers (Martin and Horne, 1995; Smith and Fischbacher, 2004, 2005), and a lack of formal, systematic and structured processes in many service organizations (Kelly and Storey, 2000; Sundbo, 1997). Instead, the way in which services often emerge from a process characterized by the conflicting interests and expectations of a variety of stakeholders has been highlighted (Smith and Fischbacher, 2004, 2005) and this can be particularly true of services such as health care. Consequently, service design has been included in the first column of Figure

20.1 as having a vital role to play in improving the quality of service experienced by both internal and external customers and, in doing so, helping to achieve behavioural change.

Conclusion

An IM approach offers opportunities to focus marketing concepts and techniques on internal organizational audiences. This is particularly relevant for social marketing programmes – e.g. smoking cessation, family planning/sexual health, alcohol reduction and early cancer screening – that rely on services, and particularly healthcare services, as co-producers of behavioural change. Research shows how the behaviour of service employees (internal customers) can have a significant impact on the behaviour of consumers (external customers). The service encounter provides the stage for role players to enact performances which will impact on their service satisfaction and quality evaluations as well as emotional reactions. Service roles differ dramatically in what is required of the people who perform them (Parish et al., 2008), and customer expectations differ across service contexts (Berry and Bendapudi, 2007). Employee behaviour may differ from that expected by customers as a result of many factors, including lack of understanding of customer requirements, role ambiguity/conflict, low self-efficacy and low levels of perceived control. Alternatively, employees may 'delight' customers through engaging in OCBs that exceed customers' expectations.

Internal marketing emphasizes internal customers and their service requirements. The service quality literature highlights 'gaps' (Chenet et al., 1999; Zeithaml et al., 1988) in organizational processes, which can ultimately result in poor service, customer dissatisfaction and consequent 'negative' behaviours. The nature of the

relationships between 'front-stage' and 'back-stage' employees and the wider range of horizontal and vertical organizational relationships will determine the level of service experienced by boundary-spanning employees. Other factors include the ability of leaders to create shared values and the vision necessary for a service climate; effective communication; the development of internal products such as customer service-focused rewards and training programmes and a holistic approach to service design. Together, these will provide an environment which generates the behaviours that will match both external and internal customer requirements.

Future directions and suggestions for research

Few social marketing studies address the issues involved in service delivery or focus on employees as target audiences. Similarly, many discussions of IM are conceptual in approach. A significant research agenda exists, which can be summarized into four main themes.

The literature suggests a sequential process whereby the adoption of an IM approach can ultimately result in external customers changing their behaviour (as illustrated in Figure 20.1). Studies within a number of service contexts have focused on specific relationships (Chung and Schneider, 2002; Rafaeli et al., 2008) or adopted a more holistic approach and simultaneously examined a number of causal relationships along the chain (Bell and Menguc, 2002; Payne and Webber, 2006). In addition, reciprocal relationships have been examined. Bell et al. (2004), for example, have assessed the impact of external customer behaviour on internal customer relationships. Research is needed at all three levels within a social marketing context to examine the nature of relationships, identify direct and indirect causal and

reciprocal effects and to develop further insights into the role of services in achieving behavioural change.

2. Further work is needed to understand the customers' evaluation of services within a social marketing context. Berry and Bendapudi (2007) describe how much of the services literature focuses on 'want services', whereas consumers may not want but need many of the services which social marketers offer. They highlight how service customers may be unwilling to perform the co-producer role: for example, when advised to make lifestyle changes such as stopping smoking. Oliver et al. (1997) state that attempts to 'delight' the customer may not be relevant in all service contexts. There is, therefore, a need for research to understand the nature of customer satisfaction and perceived service quality within these contexts. In addition, researchers are increasingly emphasizing the role of subjective affective responses (i.e. feelings and emotions), as opposed to cognition in service evaluation. Several models involving consumers' emotional responses have been developed and tested (Jang and Namkung, 2009; Oliver et al., 1997; Perugini and Bagozzi, 2001). These can be compared with alternative models such as the theory of planned behaviour (Ajzen, 1985), as predictors of behavioural change.

3. Additional contextual research is required to understand the service encounter from both the external and internal customer's perspective. Role and script theory have been adopted by service researchers to explain how consumer (and employee) dissatisfaction results from 'failure to read from a common script' (Solomon et al., 1985) and how expected role behaviours differ between actors in a service setting (Bitner et al., 1994). Ways in which service providers can identify and create common scripts and role congruence between external and internal target audiences should be explored. In particular, the ways in which an appropriate mix of formality and

adaptability can be scripted to help in responding to different target audiences would benefit many social marketing programmes.

4. Research is required which focuses on internal customers and the service which they need and receive from the organization and wider network. Multiple boundary-spanning roles may be involved in delivering a quality service to the final customer: for example, including a range of health professionals and administrative staff. Service roles vary in emotional and or physical intensity as well as knowledge and skill requirements (Parish et al., 2008). Internal market (employee) segmentation and targeting is considered to be central to IM (Rafiq and Ahmed, 1993; Varey and Lewis; 1999), yet is rarely addressed in studies. There is a need for research to identify the nature of an IM approach, including customized 'internal products and services', which will influence the behaviour of internal target audiences. In particular, the ways in which IM can encourage organizational citizenship behaviours (OCBs), directed at both internal and external customers, should be explored.

Key words: service quality; satisfaction; emotions; service encounter; employee behaviour; organizational citizenship behaviours; internal marketing; service design.

Key insights

- Social marketing programmes often rely on services and service employees to communicate with target audiences, distribute the 'social marketing product' and provide the prerequisites for co-creation of value. Consequently, the quality of service will impact on consumers' behaviour and this is particularly true of health-related behaviours.

- The services marketing literature highlights the importance of the service encounter, or 'moment of truth', in consumers' service evaluations. Here, role players (the consumer and employee) enact a 'script' and it is the failure to read from a common script which creates the potential for behavioural discord. The behaviour of service employees can have a significant impact (negatively or positively) on the behaviour of consumers through a process of service evaluation, which is also likely to include emotional reactions.

- Role and script theory suggest a dramaturlurgical metaphor where 'front-stage' staff fulfil a boundary-spanning role interacting with consumers (external customers). Front-stage (or customer-facing) employees, however, are reliant on 'back-stage' employees within the organization to provide a level of internal service quality which will enable them to serve the external customer.

- Internal marketing aims to provide the prerequisites for high levels of both internal and external service quality. An IM approach includes: the development of effective internal relationships; creation of a service climate and culture through effective leadership, shared vision and values; a focus on communication; the development of internal products and services such as rewards and training programmes; and a systematic approach to service design.

- A chain of direct causal (and reciprocal) effects has been established, linking the behaviour of consumers (external customers) to the IM activities of the organization.

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