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EXAMINING THE RELATIONSHIP BETWEEN CUSTOMER EXPERIENCE AND CUSTOMER EQUITY IN SOUTH ASIA'S HEALTH SECTOR

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Abstract
This study aims to examine the relationship between customer experience and customer equity in pre-selected private hospitals in Bangladesh. In specific, this study intends to examine the relationship between customer sensory experience, affective experience, behavioural experience and intellectual experience toward customer equity dimension (value equity, brand equity, relationship equity). Bangladesh aspires to develop its healthcare industry to meet its vast population needs. Considering the significance of customer experience and customer equity to the sustainability of the healthcare industry, this study analysed the relationships of these two constructs and examined the authenticity of the Equity Theory and the Social Exchange Theory that underpinned them. This study adopted a cross-sectional research design and distributed 500 survey questionnaires, off 500, 260 samples are acceptable for further analysis using SmartPLS. The findings revealed that customer sensory experience, affective experience, behavioural experience, and intellectual experience positively impact the customer equity dimension, namely, value equity, brand equity, and relationship equity. Furthermore, this study reveals that experiential marketing has an impact on building strong customer equity for the service organisation. This research contributes to the literature on customer experience by examining its relationship with consumer equity among respondent in private hospitals. This study has integrated Equity Theory and Social Exchange Theory to support the framework model. These findings offer empirical evidence that patients are likely to reciprocate if treated equitably by engaging in behaviours that enhance the relationship between hospital and patient.

Research paper

Keywords: Customer Experience; Customer Equity; Equity Theory; Healthcare Industry; Social Exchange Theory

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Introduction

Bangladesh is a developing country that is revolutionising rapidly due to its Vision 2021. During the last decade between 2000 and 2019, the average GDP growth rate was 6.7% per annum which is impressive, yet she faces challenges in meeting the healthcare needs of her large population. A report by the Bangladesh, Directorate General of Health Services (2018), narrated the total healthcare expenditure as a percentage of Bangladesh's GDP was only 2.37% in 2017. There is a shortage of public health facilities, scarcity of skilled workforce and inadequate financial resources, and the country is unable to use the existing resources efficiently, effectively, and equitably. With the public health system being overstretched, private health providers are left to fill the gap. Whilst public health care suffers from limited resources and manpower, private healthcare failed to gain market confidence even though there are 15,698 private healthcare across the country. This phenomenon has led many Bangladeshi from the upper and middle classes to seek medical treatment in foreign countries despite the high cost and time-consuming procedure (Rahman & Capitman, 2012). Over one million upper and middle classes patients travel abroad to seek better healthcare taking their income with them and spending it elsewhere, causing sizeable currency outflow (Khan, 2013). The lack of confidence in this area is a major obstacle in establishing a robust and resourceful private healthcare system, according to many studies (Ahsan et al., 2012; Ali, 2012; Andaleeb, 2001; Andaleeb et al., 2007; Hasin, 2011; Mahdi, 2009; Pavel et al. 2016).

Industrial Revolution 4.0 has provided access to a wide range of information that allows patients to exercise freedom when choosing healthcare providers (Wolf, 2000; Aceto et al., 2020). Organisations are impelled to manage existing resources efficiently (Roberts et al., 2008) and redefine the relationship between quality and price, utilise the limited resources efficiently, and improve service quality and overall customer perceptions to achieve sustainable and competitive advantage. This requires investigation of cost-effective initiatives (Otani & Kurtz, 2004; Otani et al., 2003; Mirzadeh et al., 2017; Radović-Marković et al., 2019) and marketing strategies that can increase patient retention to the local healthcare providers. Against this scenario, it becomes even more critical to understand the motivations behind customer behaviour. Therefore, it is crucial to identify the insights of the patients for retention purposes. Hopkins et al.'s (1994) study demonstrated that patients might not be able to determine the technical quality of medical care based on research alone; and patients judge their approval based on the level of nonmedical quality of service they received, rather than the medical services itself (Shelton, 2000). Patients expect human touch in medical care and look for experiences that directly correspond to their expectations. Only a few studies have discussed experiential issues in medical institutions, such as those by Ho et al. (2006) and Murante (2010). As per the above discussion, it is clear that experience plays an important role in patient perception.

Demand for better medical treatment has increased in Bangladesh, especially as the middle and upper classes have gained remarkable purchasing power. As a result, middle to middle-upper income classes have turned to the

private sector in India, Singapore, Malaysia, Thailand, and Australia for treatment. These affluent patients compared treatment costs between foreign hospitals, domestic private hospitals, and public hospitals. The fees in the home country were lower; however, patients agreed to pay more money for healthcare in foreign hospitals for superior service quality. Many health service providers conduct service quality surveys because customer satisfaction will result in patient's retention and customer loyalty (Fisk et al., 2013; Lovelock & Patterson, 2015). Nevertheless, some researchers claim that satisfied patients do not always equate to loyal patients (Griffin, 2002). The reason is patients rely heavily on aspects of their visit that they can see and understand, such as the physical environment, facility design, customer service, and staff interactions, to assess their satisfaction (Sweeney, 2008; Berry & Bendapudi, 2007). Therefore, experiences that drive customers to repeat services must be identified. However, many studies cover customer satisfaction in the healthcare industry, only a few study customer perceptions on equity dimension from the experiential view. Therefore, understanding the relationship between customer equity and customer experience is important to ensure marketing efforts are focused on maintaining patients coming back to them (Smith, 2011). More recent literature has emerged that organisations should move forward to experience-based marketing to gain a sustainable competitive advantage (Jha, 2018). In the same vein, Zhou, Li and Liu (2010) stressed that customer experience directly involves creating memorable feelings to win the trust and loyalty of customers and promote future sales. Therefore, a positive customer experience is an important indicator of customer retention.

This study attempts to fill the gap to understand if customer experience influences the dimensions of customer equity (Salamzadeh, 2020). This is the central research question of this study, and the objective is to examine the relationships between customer experience and customer equity dimensions.

Health professionals can no longer ignore patients' needs and demands, as globalisation and market competition has made the public more aware of health-related issues. Thus, this study goal is to assist hospitals to proactively react and change in accordance with patient needs because it is of the utmost importance to implement and develop marketing strategies that focus on the needs of the patient, as positive customer perceptions are critical for the survival and success of healthcare organisations. Because competition is increasing it has become especially important to identify the factors that impact customer loyalty. If these factors are addressed adequately, administrators can transform the healthcare delivery system. Furthermore, by understanding patient perceptions and behaviours will improve the performance of the healthcare institution and have a direct and positive impact on the clinical outcome (Tajpour et al., 2020). Patients who are satisfied with their service are more likely to follow their recommended medical treatment or regime, leading to a better health prognosis and increased patient satisfaction. In addition, the rise in patient loyalty and return behaviour may effectively improve the clinical outcome for the patient. After the introduction, the structure of this study presents the review of literature, methodology, findings, discussion, conclusion, and limitations.

Literature Review

Each industry faces obstacles in its attempts to develop its competitive advantage, and the health sector is no exception to this competition. Health facilities are subjective and time-intensive and vary from one individual to another. It makes it impossible to estimate success, to assess the consistency of the service accurately. Patients deserve the best available treatment, and thus the patient experience plays a crucial role in patient behaviour. Therefore, to increase patient retention, healthcare providers should provide their patients with a positive experience. The analysis is based on two contemporary theories of consumer behaviour and a review of philosophic justification to validate the suggested theoretical framework.

2.1 Review Stage Social Exchange Theory

The Social Exchange Theory (SET) is a convincing and robust technology for the explanation of interpersonal behaviour, according to Homans (1961), Blau (1968) and Cook *et al.* (2013). SET assumes that where any person wants anything in return, partnerships exist. The collaboration persists because the benefits and drawbacks fulfil any standards. The customer experience extends relationships, and the customer assumes that future benefits will also be gained by maintaining the relationship (Thibaut & Kelley, 1959; Wangenheim, 2003; Salamzadeh et al., 2013, 2017; Arasti & Salamzadeh, 2018). Furthermore, Garner (2017) explained that through social ties, inter-

dependence and reciprocity are fostered through the process of swapping resources. SET elements include cost (effort, time, and money), value (social standing, emotional support, or financial or material gains), result, level of contrast, happiness, and dependency. This study uses SET as the framework for understanding the consumer experience of private hospitals in investigating the relationships between people and the environment. The purpose of this study is to address the idea of consumer experience in relation to the emotions, senses, and thoughts of the consumer in terms of creating customer value, brand identity, confidence, and engagement.

2.2 Equity Theory

The Equity Theory (ET) theory suggests that all sides will have the same cost/benefit ratio for the partnership to be deemed fair (Adams, 1965). Oliver (1997) described equity as a legitimate, real or worthy good or service relative to other entities. In this theory, perception is based on different things that are involved in the transaction, such as money and time. ET deliberates that a consumer makes both internal and external judgements (Adams, 1963; Salamzadeh et al., 2019). In the cycle of demand, the user wants their input (e.g. money) to result in an equivalent value output by the organisation. Jin et al. (2016) and Oh (2000) empirical evidence shows that there is a positive relationship between perceived hospitality quality and price. Rust, Zeithaml, and Lemon (2000) said companies should spend their resources and energies to increase consumer equity instead of relying exclusively on the value of brands. ET and SET should be used to underpin the framework and assess the

partnership by illustrating the effect between consumer experience and customer equity.

2.3 Customer Experience

The definition of Consumer Experience (CEX) started in the 1980s when there was empirical data validating clients who are individuals capable of making fair and knowledgeable decisions (Holbrook & Hirschman, 1982). Consumer experience will also provide companies with a comparative advantage business (Meyer & Schwager, 2007; Pine & Gilmore, 2011; Shaw & Ivens, 2002; Shobeiri et al., 2001). Experiential marketing encourages consumers to connect and communicate with brands, goods, and services in a tactile manner. Therefore, interactions can materialise explicitly, indirectly and digitally, but often derive conceptually from the association of an entity or environment with an individual (Li et al., 2001; Nejati et al., 2011). Interactions can also occur when consumers repeatedly use the service and deal with the same organisation (McColl-Kennedy et al., 2019; Moghadamzadeh et al., 2020). The CEX construct is based on findings from Dube and Le Bel (2003), Schmitt (1999) and Brakus et al. (2009). The four CEX constructs are a sensory experience, emotional experience, behavioural experience and intellectual experience. Similarly, when extended to intangible items, experiential marketing contributes to the CEX and enhances the worth of the product or service (Williams, 2006; Borishade, 2018). Therefore, experiential marketing should be extended to many forms of business, including the healthcare sector.

2.4 Customer Equity

Rust et al. (2000) classified consumer equity (CEQ) into three categories. These groupings are equity of value, equity of relation and equity of brand (Rust et al., 2004; Richard & Jones, 2008). Rust's theory describes CEQ as "*the sum of all its consumers' discounted lifetime prices*". Thus, it is important to consider the customers' intended actions to react accordingly to the customers. Sublaban & Aranha (2009) proposed that CEQ could be characterised as the possible interest of all customers of a product. For this study, CEQ must be measured from the point of view of the consumer. A study by Kim, Kim and Hwang (2020) reported statically significant effects between customer equity and satisfaction. Rust et al. (2000) suggested that CEQ would be classified into three categories: value equity, brand equity and relationship equity. Few studies have examined the impact of experiential marketing in the healthcare industry, but there is a bigger scope for the use of experiential marketing to provide patients with meaningful interaction (Health Research Institute, 2013). The aim of this study is to determine how CEQ can be improved by expert healthcare marketing.

2.5 Development of Hypothesised Relationships

The current healthcare market is re-evaluating its business model to concentrate on helping its customers (Health Research Institute, 2012). Therefore, the purpose of this study is to examine the relationship between the user experience and the dimensions of customer equity. CEX happens as the user looks for a specific service and orders, collects and uses the item

service (Hoch, 2002; Nasution et al., 2018). According to Krishna (2012), for every company, consumer understanding, judgement, and action depends on their sense of company, and CEX has a significant effect on value equity. Thus, once they have a good experience (Mittal & Kamakura, 2001; Salamzadeh et al., 2013), consumers are more likely to endorse a brand or buyback. In addition, many scholars observed that label familiarity has a favourable impact on brand equity. Schmitt (1999) argued that the CEX is the perfect branding for a product or service. There is also an observational analysis that acknowledges that promoting meaningful experience can lead to a continuance of patients (Gentile et al., 2007; Rose et al., 2012; Al-Wugayan, 2019). The following hypotheses are proposed in this study:

H1: Sensory Experience has a significant direct impact on Value Equity.
H2: Affective Experience has a significant direct impact on Value Equity.
H3: Behavioural Experience has a significant direct impact on Value Equity.
H4: Intellectual Experience has a significant direct impact on Value Equity.
H5: Sensory Experience has a significant direct impact on Brand Equity.
H6: Affective Experience has a significant direct impact on Brand Equity.
H7: Behavioural Experience has a significant direct impact on Brand Equity.
H8: Intellectual Experience has a significant direct impact on Brand Equity.
H9: Sensory Experience has a significant direct impact on Relationship Equity.
H10: Affective Experience has a significant direct impact on Relationship Equity.

H11: Behavioural Experience has a significant direct impact on Relationship Equity.

H12: Intellectual Experience has a significant direct impact on Relationship Equity.

Figure 1 is the framework for this analysis which will analyse the systemic relationships of CEX and CEQ. CEX structures are sensory, intellectual, behavioural, and affective interactions, as variables that result in value equity, relationship equity, and brand equity components of the CEQ.

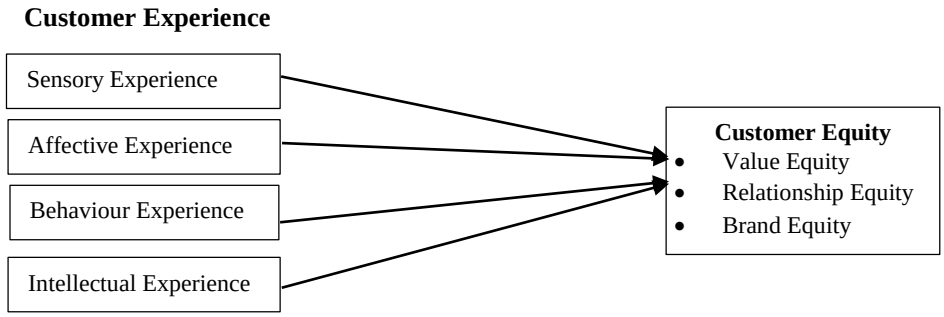

Figure 1. Theoretical Framework

Methodology

The quantitative approach is used for this analysis. The quantitative approach has been chosen since the purpose of this analysis was to establish the statistical association between the dimensions of CEX and CEQ. The research population are individuals that have been treated at least once in preselected private hospitals in the past three years, who are at least 18 years of age who have been able to remember their experience during their time in the

clinical hospital. Specific criteria for selecting the hospitals were defined: the hospitals had more than 200 beds, they were multidisciplinary, renowned, and they served a broad range of socioeconomic groups. In Bangladesh, 17 major hospitals were chosen on the basis of their competitiveness. In this study, the unit of analysis included the individuals who met the inclusion criteria. Samples from this analysis were collected using the technique of judgmental sampling. Data were obtained via interviews with Mall-intercept and placed nearest to the hospitals under study. Hair *et al*. (2010) proposed that an appropriate sample size would be a sample size ratio of 5:1 to 10:1 with the number of constructs analysed. For SEM studies, a sample size of 200 to 400 is therefore sufficient. Two hundred samples were deemed appropriate in this analysis. Eight districts from the eight divisions that are Dhaka, Barisal, Chittagong, Jessore, Bogra, Dinajpur, and Sylhet, took part. These districts are chosen because they are large, densely populated cities with superior economic growth and private clinics or hospitals (Bangladesh Bureau of Statistics, 2013). Data were gathered using a self-administered questionnaire and was designed to suit the objective of the analysis. The scale used to measure the effect of customer experience was originally adapted by Brakus et al. (2009), Lin et al. (2009) and Nadiri & Gunay (2013). For customer equity, the authors applied the measurement developed by Moliner (2009). However, slight changes were made to fit the current research.

Findings

Of the 500 questionnaires distributed, we secured 310 answered questionnaires. A data cleaning and screening was conducted to remove incomplete questionnaires and classify missing values and outliers using the statistical descriptive and box plot methods. In the end, 50 questionnaires were excluded due to incompleteness and a few high-frequency outliers. Two hundred sixty of the questionnaires are acceptable, with a response rate of 52%. Following the recommendation of Cohen's (1992) and introducing an 80% statistical power and a 5 % significance standard, the sample size is appropriate because it met the recommendation. Patient age ranged from 18 to 68 years, and the mean age was 32.09 (SD:10.40). Of the respondents, 60 per cent are male. Of the respondents, 59.6 per cent were married. In the last three years, 61.2% of respondents were admitted to the same hospital only once, while 23.8% of respondents were admitted twice in the last three years. The majority of respondents (90 per cent) are Muslim. 32.7% of respondents were Bachelor and Higher Secondary School graduates (26.9%) and Master graduates (21.9%). Approximately 13.5 per cent of respondents indicated the highest level of education they had completed was in or below the secondary school. Only 0.8% of respondents reported having a doctoral degree. Approximately 4.2% of respondents identified certain types of education, including special needs or self-education. About 38.5 per cent of respondents were currently working and 13.8 per cent self-employed. 25.8 per cent were students, 14.2 per cent were household makers, and 3.5 per cent were unemployed.

Merely 4.2% of respondents identified other occupations. Approximately 55.4% of the household income of the respondents was less than BDT 50,000 per month. 20% of household income was between 51000 and 75000 BDT, and 4.6% of household income was more than 200000 BDT per month.

4.1 Common Method Bias (CMB)and Goodness of Measures

This research used a self-reporting method and discussed the role of CMB in the review. Therefore, Harman's single factor check was carried out. The findings showed that the seven constructs explained 65.78 per cent and 48.98 per cent of the variance and suggested that the overall variance was not solely due to a single factor. The quality, relevance, and validity of the calculation model were measured using SmartPLS Version 3.0 before the final findings were reported. The model propositions that the CEX (sensory experience, affective experience, behavioural experience, and intellectual experience) are the antecedents of the CEQ dimensions (value equity, brand equity, relationship equity). The first step involved examining the loads for each individual item. Table 1 reveals that the AVE of the structures is over 0.5, which is appropriate.

Table 1. Reliability of Reflective Constructs

Constructs	Items	Loadings	AVE	CR	Items deleted due to low loadings
Sensory Experience (SENEX)	SENEX_1	0.834	0.702	0.922	
	SENEX_2	0.881			
	SENEX_3	0.847			
	SENEX_4	0.843			
	SENEX_5	0.782			
Affective Experience (AFFEX)	AFFEX_1	0.812	0.694	0.872	
	AFFEX_2	0.874			
	AFFEX_3	0.812			
Behavioural Experience (BEHEX)	BEHEX_2	0.756	0.616	0.865	BEHEX_1
	BEHEX_3	0.749			
	BEHEX_4	0.835			
	BEHEX_5	0.797			
Intellectual Experience (INTEX)	INTEX_1	0.773	0.658	0.906	
	INTEX_2	0.867			
	INTEX_3	0.856			
	INTEX_4	0.790			
	INTEX_5	0.763			

Note: Loadings >0.7, AVE-Average Variance Extracted >0.5, CR- Composite Reliability>0.7

Table 2. Reliability for second order constructs

Constructs	Items	Loadings	AVE	CR
Value Equity (VALEQ)	VALEQ_1	0.830	0.657	0.851
	VALEQ_2	0.878		
	VALEQ_3	0.867		
	VALEQ_4	0.736		
	VALEQ_5	0.821		
	VALEQ_6	0.836		
	VALEQ_7	0.848		
	VALEQ_8	0.928		
	VALEQ_9	0.892		
Brand Equity (BRAEQ)	BRAEQ_1	0.836	0.902	0.948
	BRAEQ_2	0.823		
	BRAEQ_3	0.781		
	BRAEQ_4	0.840		
	BRAEQ_5	0.877		
	BRAEQ_6	0.862		
Relationship Equity (RELEQ)	RELEQ_1	0.823	0.827	0.905
	RELEQ_2	0.845		
	RELEQ_3	0.827		
	RELEQ_4	0.799		
	RELEQ_5	0.862		
	RELEQ_6	0.831		

Note: AVE-Average Variance Extracted, CR-Composite Reliability; AVE and CR were calculated manually for first-order constructs

Table 3. Discriminant validity of constructs

	AFFEX	BEHEX	BRAEQ	INTEX	RELEQ	SENEX	VALEQ
AFFEX	**0.833**						
BEHEX	0.657	**0.785**					
BRAEQ	0.712	0.710	**0.950**				
INTEX	0.666	0.690	0.708	**0.811**			
RELEQ	0.703	0.709	0.770	0.681	**0.909**		
SENEX	0.754	0.714	0.784	0.738	0.764	**0.838**	
VALEQ	0.705	0.675	0.767	0.674	0.777	0.752	**0.811**

Note: 1. Diagonals represent the square root of the AVE while the off- diagonals represent the correlation; 2 AVE=Average Variance Extracted, SENEX=Sensory Experience, AFFEX=Affective Experience, BEHEX=Behavioural Experience; INTEX=Intellectual Experience, VALEQ=Value Equity, BRAEQ=Brand Equity, RELEQ=Relationship Equity

4.2 Assessment of the Structural Model Direct Relationship

All variables in this sample had R^2 values varying between 0.639 and 0.711. The effects of the direct effect are reported in Table 4. The value of VALEQ R^2 was 0.639, indicating that 63.9 per cent of the variation in value equity can be attributed to intellectual experience, behavioural experience, affective experience, and sensory experience. Intellectual experience ($\beta = 0.142$, $p < 0.05$), behavioural experience ($\beta = 0.176$, $p < 0.01$), affective experience ($\beta = 0.234$, $p < 0.01$), and sensory experience ($\beta = 0.346$, $p < 0.01$) have been shown to be positively linked to Value Equity in this study. BRAEQ returned a value of 0.690 for R^2. This indicates that 69% of the variation in brand equity is due to intellectual experience, behavioural experience, affective experience, and sensory experience. It was also shown that intellectual experience ($\beta=0.167$, $p<0.01$), behavioural experience ($\beta=0.207$, $p<0.01$), affective experience ($\beta=0.181$, $p<0.01$), and sensory experience

(β=0.376, p<0.01) are positively related to brand equity. As a result, H5, H6, H7 and H8 of this study were supported. The R^2 value of the relationship equity (RALEQ) was determined to be 0.663. This means that 66.3 per cent of the variation in RALEQ can be explained by intellectual experience, behavioural experience, affective experience and sensory experience. Intellectual experience (β=0.123, p<0.05), behavioural experience (β=0.244, p<0.01), affective experience (β=0.195, p<0.01) and sensory experience (β=0.352, p<0.01) were found to be positively correlated with relationship equity. As a result, H9, H10, H11 and H12 of this study were supported.

Table 4. Hypothesis Testing

Hypothesis	Relationship	Std. Beta	Std. Error	T-Value	Decision
H1	SENEX -> VALEQ	0.346	0.063	5.493**	Supported
H2	AFFEX -> VALEQ	0.234	0.056	4.186**	Supported
H3	BEHEX -> VALEQ	0.176	0.059	2.983**	Supported
H4	INTEX -> VALEQ	0.142	0.059	2.406**	Supported
H5	SENEX -> BRAEQ	0.376	0.066	5.706**	Supported
H6	AFFEX -> BRAEQ	0.181	0.061	2.988**	Supported
H7	BEHEX -> BRAEQ	0.207	0.054	3.816**	Supported
H8	INTEX -> BRAEQ	0.167	0.054	3.121**	Supported
H9	SENEX -> RELEQ	0.352	0.069	5.098**	Supported
H10	AFFEX -> RELEQ	0.195	0.064	3.060**	Supported
H11	BEHEX -> RELEQ	0.244	0.061	4.018**	Supported
H12	INTEX -> RELEQ	0.123	0.065	1.886*	Supported

Note: **p<0.01(2.33), *p<0.05(1.645

4.3 Predictive Relevance (Q^2)

Calculating Q2 is achieved using two methods. The methods are the cross-validated communality (H2) and the cross-validated redundancy (F^2). This research employed the cross-validated redundancy (F^2) methodology. Q^2 values greater than 0 imply that the model is of predictive significance, as is the case for all of the above items. The predictive significance values are listed in Table 4, and the tests are above 0.

Conclusion

With globalisation and the revolution in today's communication, retaining customers and attracting future customers is a vital strategy for all organisations. The social media influence has increased the consumers' awareness. More educated customers are seeking a higher level of customer quality that is comparable to the price charged. It is a timely study because, in this era, providing good service quality is not enough. Organisations need to look beyond service quality to retain customers and able to sustain in this competitive business. This study views the customer experience (CEX) as an antecedent of the dimensions of customer equity (CEQ), suggesting that experience will affect the customer's insight into the dimensions of customer equity. The findings indicate that all constructs had a positive impact on all CEQ dimensions. This implies that CEX has a positive influence on the equity dimensions of customer perceptions. This study found that CEX influences the value of the customer, which is consistent with Krishna's (2012), which

suggests that consumer sensory experiences affect their perception, judgment, and behaviour. A postulation can be made that sensory experience relates to the aesthetic appeal of the hospital the moment a patient enters it. It is also postulated that sight and smell are the essential factors for the patients to establish a pleasant sensory experience. The sensory experience is an intense one, as the patient uses all the senses to grasp his / her surroundings. Furthermore, a positive sensory experience will help to provide a sense of completeness, motivation, joy, and contentment while also decreasing anxiety levels (Harman, 2002). The feelings of the patient are that affective experience. Parker (2006) argues that discovery, anticipation, mental stimulation, and exploration are about emotions and feelings. Similarly, intellectual experience is derived from customer knowledge. The study suggests that roughly 67.3 per cent of the value equity variance can be attributed to these four dimensions of customer experience. As a consequence, we can conclude that a good customer experience will affect the decision of the consumer and the understanding of value equity in the context of healthcare.

The study also reveals that about 71.2% of the variation in brand equity can be traced to these four dimensions of consumer experience. Therefore, it can be shown that the patient's experience in a hospital environment can affect the insight of brand equity by the consumer. This study also found that relationship equity was substantially related to sensory experience, affective experience, behavioural experience and intellectual experience. Therefore, it can be hypothesised that a successful CEX will establish a long-lasting emotional bond between the brand and the consumer. Based on experience,

patients shape their perceptions of trust and commitment. The study suggests that the four facets of customer experience can be related to around 74.4 per cent of the variation in relationship equity. Therefore, it can be inferred that CEX affects the perception of relationship equity in the healthcare framework. Apart from the aforementioned, this research contributes to the literature on customer experience by examining its relationship with consumer equity. It also conformed to the theory of social exchange and equity. Essentially, these findings offer empirical evidence that patients are likely to reciprocate if treated equitably by engaging in behaviours that enhance the relationship between hospital and patient.

Limitation and future research

Firstly, this study adopted a cross-sectional design where all data was obtained from a single time period. The findings were not able to capture the dynamics of the customer experience and, particularly, their long-term effects on service loyalty. Further studies in this area should employ a longitudinal methodology to capture changes in customer perception over a long period of time. This will help to get a better picture of the relationship between customer experience, perception of customer equity, and service loyalty. Secondly, the data in this study was based on feedback from the patients, with no feedback provided from hospital staff and doctors. The questionnaire was structured in such a way that only patients who have previous experience that can recall their experiences were chosen as respondents. Therefore, the issue

of common method variance is likely to arise. The methodology used in this study included a pre-testing procedure and a single factor test to ensure common method variance would not be a concern. However, this is still reported as a study limitation. In addition, this study emphasises the customer perspective to measure the customer experience and customer equity. Future research may look at the organisation's perspective to better understand the priority the organisation places on customer experience design and the dimensions of customer equity. This will bring new light to the marketing literature.

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