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**Should I book another hotel? The effects of sickness and ethnicity on customer brand loyalty and positive word of mouth.**

**Abstract**

Sickness presenteeism is working despite feeling sick. Although presenteeism prevails across different job sectors, few studies have focused on how it affects the hospitality sector. This study applied a quasi-experimental method to investigate how sick employees' presence affects customers' fear of contagion and, consequently, customer brand loyalty (i.e., return intentions) and positive word of mouth (i.e., recommendation intentions) due to perceived service failure. The effects of ethnicity on customers' intentions were also explored. Data were collected from 581 participants. The results reveal that, when hospitality employees appear to be sick, customers have weaker recommendation and return intentions compared to when employees do not show any sickness. In addition, our results show that due to perceived ethnic dissimilarity, *customers do not tend to withdraw from non-similar sick employees, not showing weaker recommendation and rebooking intentions toward tourist accommodations.* This research enriches the very well established literature on consumer-brand relationships, sickness presenteeism and social cognition, as well as furthering practice by showing that sickness presenteeism, when correctly managed, can generate organizational advantages.

**Keywords:** Sickness presenteeism, customer loyalty, positive WOM, ethnicity, hospitality sector.

## Introduction

The concept of sickness presenteeism has emerged in recent years as a promising topic of investigation (Johns, 2011). This concept refers to “attending work despite being ill” (Martinez & Ferreira, 2012, p. 297). Sickness presenteeism appears as a relevant psychological phenomenon where employees are physically present at work despite poor health conditions and become less productive as a result. This is now known to generate a down-stream on individuals’ health and negatively impact companies’ performances, creating costs for organizations and the society when it’s not managed correctly (Evans-Lacko & Knapp, 2016; Miraglia & Kinman, 2017).

This type of presenteeism prevails across different job sectors, with higher rates among education and health and welfare organizations (e.g., Aronsson, Gustafsson, & Dallner, 2000; Bergström et al., 2009; Ferreira, Costa Ferreira, Cooper, & Oliveira, 2018; Ferreira & Martinez, 2012; Martinez & Ferreira, 2012). However, the literature on presenteeism shows that the role of sickness presenteeism in the hospitality and tourism sector has not been sufficiently studied. Indeed, Arslaner and Boylu, (2017) reinforce that there is a growing need for new research to develop policies related to hotel employees’ health problems and to highlight the significance of the hotels’ support to their employees due to the costly consequences associated with sickness presenteeism. In the hospitality industry, especially in hotels, sickness presenteeism behaviors tend to appear because of jobs’ inherent characteristics, such as being labor-intensive and often based on human relationships. Reasons for presenteeism’s prevalence include a stressful work atmosphere due to intense human interactions, long work hours related to the 24/7 nature of services, and constantly changing shifts (Boylu & Arslaner, 2015). Particularly because of the constant face-to-face interactions between hotel employees

and customers, employees who show up for work despite being sick or not feeling well may negatively affect customers (e.g., causing dissatisfaction).

Nonetheless, the literature on how sickness presenteeism affects customers and consequently hotels is still scarce. This lack of research calls for studies that englobe not only the individual level but also the organizational level of analysis, including pertinent queries regarding how this organizational phenomenon affects service quality expectations and consequently threatens the industry profitability. To fill this gap, the present study sought to investigate how customers' intentions to recommend (i.e., to spread positive word of mouth [WOM]) and return to (i.e., to show customer loyalty) hotels are influenced by employees' sickness presenteeism behaviors. Undeniably, this issue gains relevance due to the defraud of customers' expectations of what should be a quality service. Specially in the hospitality sector, having an encounter with a visibly sick employee may be perceived as a service failure as it threatens the customer's expected safety and security that he or she expects to be one of the main concerns for the company (Hemmington, 2007).

Additionally, we examine the effects of ethnicity on this query since researchers have reported that the hospitality industry has a strong tradition of workforce diversity (Baum, 2012), and to the extent of our knowledge no research has explored the relationship between sickness presenteeism and customer loyalty and positive WOM in terms of ethnicity dissimilarity perceptions. Still, although it is known that the general sustainability of industries and consequently economies continue to be contingent on foreign employees – especially the hotel industry due to their inherent characteristics (Joppe, 2012) -, this reality has raised some concerns, namely, regarding prejudice toward employees belonging to ethnic minorities.

It is acknowledged that when workers from certain cultures are expected to

provide services to customers from diverse cultural and ethnic backgrounds, this increases the likelihood of misinterpretations that could lead to dissatisfied customers (Zopiatis, Constanti, & Theocharous, 2014). This may occur due to service failure perceptions. Studies focusing on perceived threats of disease (e.g., Schaller, Park, & Faulkner, 2003) have also shown that cues to foreign origins promote behavioral responses such as avoidance, disgust, and physical distancing in individuals who seek to avoid diseases. These disease-avoidance mechanisms may play a role on customers withdrawal from customer-service encounters when employees belong to unfamiliar ethnic out-groups (Schaller et al., 2003), especially when they display sickness symptoms.

Drawing on the social identity theory (SIT) (Tajfel & Turner, 1979) this may happen due to inherent tendency that individuals have to actively evaluate in-group members more favorably and out-group members more unfavorably. This predisposition may influence customers perception of service quality. When customers encounter a noticeably sick employee, they are facing a hotel that fails to provide them with security and health safety and therefore delivers a service that is not meeting or exceeding the customers' service expectations. This customer perception of service failure may be even stronger when employees are dissimilar than when they belong to the same ethnic group.

The pertinence of studying these issues' organizational consequences in the travel and tourism sectors is linked with the fact that they have increasingly become key driving forces of socio-economic progress through the generation of jobs, export income, and infrastructure development in many countries around the world (World Tourism Organization, 2018). We opted to focus particularly on Portugal's tourism sector since it has also become an increasingly significant economic sector (Ferreira,

Martinez, Lamelas, & Rodrigues, 2017). In recent years, Portugal has become a quite popular international tourist destination. In both 2017 and 2018, Portugal was named “best European tourist destination” in the World Travel Awards (2018). This sector’s total contribution to the 2017 Portuguese GDP was 33.5 billion euros (€) (38.0 billion United States [US] dollars), corresponding to 17.3% of the GDP, and this figure is forecast to rise by 5.1% in 2018 (World Travel & Tourism Council [WTTC], 2018). Moreover, in 2017, the tourism sector contributed directly to the creation of 401,500 jobs (i.e., 8.5% of total employment), and this number is expected to rise by 4.9% in 2018 (WTTC, 2018). The jobs created and the associated working conditions are crucial to the sector’s continued success, and thus these should be critically analyzed (Carvalho, Costa, Lykke, & Torres, 2014).

Moreover, the hospitality workforce is characterized by globally-shared characteristics. Employees tend to have low levels of education (Santos & Varejão, 2007), and hospitality occupations tend to be unskilled and feminized. Salaries are also relatively low (Nickson, 2007), and jobs often require employees to work beyond scheduled hours and/or imply shift work (Costa, Carvalho, & Breda, 2011; Nickson, 2007; Parrett, n.d.). In addition, employment contracts are often short-term, informal, or nonexistent (Parrett, n.d.), and tourism jobs are both demanding and tend to offer poor working conditions (Nickson, 2007).

According to Johns (2010), poor job conditions such as those in the hospitality industry comprise high job stress, inadequate reward systems, threats to job security, heavy job demands, and a presence culture (e.g., Ferreira, Martinez, Cooper, & Gui 2015). These all constitute known sickness presenteeism antecedents (Johns, 2010). Although various researchers have already sought to analyze different contexts with high levels of sickness presenteeism, few studies have specifically focused on the

hospitality industry. This presenteeism generally results in significant reductions in productivity in terms of quantity since employees' production fails to meet work objectives mainly due to difficulty concentrating. In addition, the quality of work suffers due to errors and omissions in procedures (Martinez & Ferreira, 2012).

According to Deery and Jago (2009), hospitality and tourism-related cultural patterns promote presenteeism behaviors. This happens mainly due to the intensive work that characterize the high season, during which hotel employees do not have enough time to rest and, consequently, are more susceptible to diseases. Due to nowadays context of economic uncertainty and to the climate of insecurity in the hospitality industry, employees also tend to continue to show up for work despite the negative consequences of sickness presenteeism as they are afraid of losing their jobs or being replaced by other employees (Boylu & Arslaner, 2015). By doing so, employees are not only affecting their own productivity, wellbeing at work, and health, but also harming their companies' organizational performance and success (Ferreira & Martinez, 2012).

All along, this evidence has highlighted the need to study how hospitality employees' sickness presenteeism behaviors impact important organizational outcomes, such as service quality and consequently companies' profitability. Thus, given the existing diverse workforce in the hotel industry, understanding how both ethnicity and sickness symptoms affect customers is important because these can influence intentions to recommend and return to hotels which has impact on customers brand loyalty and service quality.

## **Literature Review**

### **Sickness presenteeism in the hospitality industry**

Owing to the tourism industry's 24/7 nature and "face-time" culture, hospitality work is widely regarded as stressful (Zhao & Ghiselli, 2016). Individuals working in

this industry are constantly exposed to occupational stressors that may cause them to experience burnout (Asensio-Martínez et al., 2017). Hospitality employees are continuously exposed to high levels of stress not only due to the types of tasks they are required to perform but also because of the emotional valence associated with their work. This is due to their constant interaction with and reliance on others (e.g., managers, coworkers, and customers) (Kim, 2008; O'Neill & Davis, 2010).

Poor job conditions and highly demanding work associated with aversive and complex social interactions can be both psychologically and physically detrimental to hospitality employees due to increased levels of burnout and stress. Such adverse conditions can have various negative consequences for workers' wellbeing and health. These include, among others, eating disorders (e.g., Torres & Nowson, 2007), cardiovascular diseases (e.g., Melamed, Shirom, Toker, Berliner, & Shapira, 2006), substance abuse (e.g., Cunradi, Chen, & Lipton, 2009), and depression and anxiety (e.g., Schonfeld & Bianchi, 2016).

Most studies about sickness presenteeism in the hospitality industry focus primarily the effects of work demands on employees' health and productivity, often neglecting the negative organizational consequences that may derive from this phenomenon. Due to this, in order to bridge this gap, in this study we searched for a broader perspective on sickness presenteeism, by focusing on the possible consequences of this recurrent behavior at the organization level (Arjona-Fuentes, Ariza-Montes, Han, & Law, 2019). In fact, the literature show that besides heavy workloads, sickness presenteeism is important in hospitality industry because jobs tend to be not only labor-intensive but also based on human relationships (Boylu & Arslaner, 2015). Due to this, in this industry, employees' sickness may affect more than just individuals' performance, wellbeing, and health as co-workers (e.g., damaged team dynamics)



(Luksyte, Avery, & Yeo, 2015) and customers' perceptions (e.g., more dissatisfaction) can be influenced (Boylu & Arslaner, 2015). The latter cited authors report that this happens because employees' physical and mental conditions are reflected in service quality, customer satisfaction, and, ultimately, their company's productivity and profitability.

### **Service quality and customer brand loyalty in the hospitality industry.**

Due to the evolution and increasingly competition of the service sector, companies are determined to retain and hold their customers (Aksoy, 2013). Because of this evolution, delivering a quality service is one of the challenges of all service companies, including hospitality. Service quality has become a key driver of businesses' performance and it has been documented in the literature as being a booster of customer satisfaction and a customer loyalty downsizer (Wilkins, Merrilees, & Herington, 2007). In the hospitality industry, the value of service quality to the businesses' performance is well established (Pizam & Ellis, 1999).

According to Bitner, Booms and Stanfield (1990), perceived service quality stems from the individual service encounter between the customer and the service employee, during which the customer assesses quality and develops satisfaction or dissatisfaction toward the service. The service experience is usually evaluated by customers based on their expectations – determined by intrinsic and extrinsic cues associated to a certain accommodation experience, by a global viewpoint built from previous accommodation experiences and other information sources (Gould-Williams, 1999) - and used to evaluate quality, to ascertain satisfaction and to form expectations about future consumption experiences (Yi & La, 2003).

There are several aspects of hotel services that can be evaluated by customers and that mirror their satisfaction toward them. Among them, the following have been

ranked as vital: cleanliness (placed as the most important, e.g., clean bedroom and bathroom); quality staff and service (e.g. politeness of staff, efficacy of service, responsiveness of staff, promptness of service, friendliness of staff), and safety and security (e.g., Callan & Bowman, 2000; Lockyer, 2002).

The literature propose that service quality is antecedent to customer satisfaction and that customer satisfaction is antecedent to customer loyalty (e.g., Caruana, 2002; McDougall & Levesque, 2000). Indeed, investigation with frontline employees and customer interactions state that customer-oriented behavior of service employees is crucial for the success of service encounters and to increase customer satisfaction and loyalty (e.g., Stock, 2016; Wieseke, Geigenmüller, & Kraus, 2012).

#### **Customer brand loyalty and WOM.**

Over the last decades, the service sector (e.g., hotels) has experienced an extraordinary evolution which has raised consumerism by making customers more active and demanding, which turned the concept of customer brand loyalty even more central to both marketing scholarship and practice (Khamitov, Wang, & Thomson, 2019; Toufaily, Ricard, & Perrien, 2013; Van Lierop & El-Geneidy, 2016). Hospitality organizations currently acknowledge that their existence and growth is contingent on their ability to create exclusive, unforgettable, and positive experiences for customers (Walls, Okumys, Wang, & Kwun, 2011). Thus, hospitality companies are betting on personalized experiences that link these firms with their customers and facilitate the development of brand ambassadors and co-creators of value, thereby enhancing customer loyalty and company profitability (Kandampully, Zhang, & Bilgihan, 2015). Also, scholars have shown that consumer-brand relationships (CBRs) are a powerful mechanism in building customer brand loyalty (Khamitov et al, 2019). Therefore, we may find in the literature five main concepts to mirror the relationships established

between consumers and brands: brand attachment, brand love, self-brand connection, brand identification, and brand trust (see Table 1).

Table 1. *Consumer-brand relationships concepts' definitions.*

| <b>Concepts</b>       | <b>Definition</b>   | <b>Authors</b>                                     |
|-----------------------|---|--|
| Brand attachment      | “Emotion-laden target-specific bond between a person and a specific brand”.   | Thomson, MacInnis, & Park, 2005, p. 78.            |
| Brand love            | “Degree of passionate emotional attachment a satisfied consumer has for a particular trade name”.   | Carroll & Ahuvia, 2006, p.81.                      |
| Self-brand connection | “The extent to which individuals have incorporated brands into their self-concepts” with consumers using brands to express who they are or who they aspire to be. | Escalas & Bettman, 2003, p.340.<br>Escalas 2004.   |
| Brand identification  | “A consumer's perceived state of oneness with a brand”.   | Stokburger-Sauer, Ratneshwar, & Sen, 2012, p. 407. |
| Brand trust           | “The willingness of the average consumer to rely on the ability of the brand to perform its stated function”.   | Chaudhuri & Holbrook, 2001, p.82.                  |

It is known that these different CBR features are positive predictors of customer brand loyalty (Homburg, Wieseke, & Hoyer, 2009; Mazodier & Merunka, 2012). Although Khamitov et al. (2019) recent meta-analysis shows that from the five main brand relationship constructs, love-based and attachment-based brand relationships are most strongly linked to customer brand loyalty, in our study we will focus mainly on brand trust to explain the relationships established between consumers and brands and customer brand loyalty. Undeniably, literature as shown that brand trust is a reliable predictor of customer brand loyalty, since it has been shown to be effective

at creating or reinforcing customer brand loyalty. Indeed, it is known that brand trust is a reliable predictor of repeat purchase (Ashworth, Dacin & Thomson, 2009). Thus, due to the positive impact of brand trust on customer brand loyalty, this concept can be conceptualized as a brand loyalty driver.

According to Chaudhuri and Holbrook (2001, p. 82), brand trust can be defined as “the willingness of the average consumer to rely on the ability of the brand to perform its stated function”. It’s related not only to the consumers’ belief that the brand is honest and safe, and to the subjective feelings of reliance on the brand (Khamitov et al., 2019). But is related also to the feeling of security held consumers that the brand will meet their consumption expectations (Delgado-Ballester & Munuera-Alemán, 2001).

Loyal customers are willing to pay more for hospitality services, express stronger buying intentions, and resist switching companies (Evanschitzky et al., 2012). Customer loyalty is thus one of firms’ most enduring assets (Kandampully et al., 2015), allowing them to achieve long-term competitive advantages in competitive global markets (Aksoy, 2013) by creating mutually beneficial long-term relationships with their customers (Kandampully et al., 2015).

According to the literature, currently, customer WOM is considered a central element of customer loyalty (Garnefeld, Helm, & Eggert, 2011). When customers act as brand ambassadors, they become one of the most important assets contributing to hospitality companies’ success (Solnet & Kandampully, 2008). This is mainly because hospitality companies’ services cannot be tested prior to acquisition (Ng, David, & Dagger, 2011), which makes customer WOM a valuable information source—online and offline—to those evaluating service quality. Loyal customers are credible WOM providers who help attract friends, family, and other potential customers to businesses

(Garnefeld et al., 2011) since WOM serves as peer guidance that can influence consumers' decision making, product evaluations, and purchase intentions (Kandampully et al., 2015). For instance, Gremler and Gwinner (2000) observe that rapport reflects customers' perceptions of enjoyable interactions with employees and correlates positively with trust (Macintosh, 2009). However, interactions between customers and employees may cease to be enjoyable and positive if workers display symptoms of illness or impaired health.

Customers expect safety and security in hotel services a sign of service quality. According to Hemmington's (2007) hospitality experience framework, customers safety and security emerge as one of the five dimensions of customer experience, along with the host-guest relationship, generosity, theatre and performance and small surprises. This framework focus on how to provide customers with experiences that are personal, unforgettable and valuable to their lives, which ultimately drive their intention of consuming again. Focusing on the safety and security dimension, Hemmington (2007) state that this is an aspect that is often neglected and possibly not sufficiently recognized and that customer's security in hospitality should be the primary concern rather than on hospitality resources and procedures security. Thus, maintaining customers safety and security is one of the main services that hotels should offer. Hence, when people are worried about contracting a disease, they try to escape or distance themselves from the source of infection (Luksyte et al., 2015). Accordingly, when a hotel lets a visually sick employee serve customers directly, while threatening to contaminate them, we are facing a hotel that threatens customers safety and fails to provide the expected service quality in a consistent manner. Thus, in this study we conceptualize the encounter between a customer and a visibly sick employee as "service

failure”, since if a hotel allows a sick employee to serve customers, it is actively compromising the health safety of the customer.

Therefore, we propose that if employees are sick, customers will tend to avoid these staff members, which may decrease their trust in, satisfaction with, and loyalty to the hospitality company in question and generate negative WOM. Likewise, this might tend to occur because the customer perception of poor quality of service might lead to less customer loyalty even in the case of a non-recurrent service failure.

To test this assumption, we have created a quasi-experimental design based on a two-time evaluation. First, we started by asking respondents (i.e., T1) to evaluate their last tourist accommodation experience (i.e., recommend and return intentions) without presenting to the respondent any sickness cue. Then, to test for the possible effect of hotel employees’ sickness symptoms (i.e., sickness presenteeism) on customers’ evaluations, we provided a sickness cue to the respondents (scenario manipulation). We then asked the respondents to evaluate how likely they were to recommend and return to the last tourist accommodation where they had stayed if they had an encounter with a sick employee (i.e., T2) (see Figure 1). A more detailed explanation about our quasi-experimental design can be seen in our method section.

Thus, the following hypothesis was proposed for the present study:

*Hypothesis 1a:* Employees’ sickness impacts the relationship between customers’ recommendation intentions (i.e. to positive WOM) toward the tourist accommodation in question at Time 1 (T1) and customers’ recommendation intentions toward the same tourist accommodation at Time 2 (T2).

Thus, when employees show symptoms of an illness, customers will have weaker recommendation intentions toward the tourist accommodation in question compared to

when employees do not show any symptoms. This led us to formulate the second part of this hypothesis:

*Hypothesis 1b:* Employees' sickness impacts the relationship between customers' return intentions toward the tourist accommodation in question at T1 and customers' return intentions toward the same tourist accommodation at T2.

In other words, when employees show symptoms of illness, customers will have weaker return intentions toward the tourist accommodation in question compared to when employees do not exhibit any symptoms.

### **Workforce diversity in the hospitality industry**

As mentioned above, the hospitality industry has a strong tradition of workforce diversity particularly in terms of the role that foreign employees have played since this industry's earliest development (Baum, 2012). This ethnically diverse workforce has emerged as a way to cope with the seasonality and fluctuating demand that characterize the industry (Joppe, 2012) and its sustainability and consequently economies continue to depend in part on foreign employees. In fact, the International Labor Organization (2015) states that employing a diverse workforce and managing it effectively offer benefits to businesses.

Nevertheless, since service co-production emerges as a crucial service feature with a visible social component attached to it, perceived ethnic differences between customers and employees may have negative implications for the service quality assessment. Thus, to explain the relationship between fear of contagion and employees' ethnicity, this study's assumptions were drawn from SIT (Tajfel & Turner, 1979). In addition, based on recent studies in this field, we used the term ethnicity to denote both

cultural groupings and groupings defined by culturally-determined physical markers such as skin tone (e.g., Richeson & Sommers, 2016).

SIT defends that individuals use social comparisons to organize their social world and process information about other individuals and/or groups (Tajfel & Turner, 1979). This theoretical approach defends three main ideas. First, individuals are motivated to maintain a positive self-concept (i.e., as “I” and “me”). Second, individuals’ self-concept derives mainly from group identification, and social behavior structures their sense of themselves as members of social groups (i.e., as “us and “we”). Last, individuals establish positive social identities by favorably comparing their in-group against out-groups and see themselves as having more positive attributes than others do (Haslam, 2014; Operario & Fiske, 1999).

Hence, SIT is tightly linked to self-categorization theory (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987), since in the pursuit of a salient social identity, people are motivated and tend to emphasize as much as possible positive intergroup distinctiveness (Hogg & Abrams, 1988). This tendency can be characterized as a positive self-concept as a result of a favorable comparison of their in-group to an outgroup on important dimensions and attributes (Böhm, Rusch, & Baron, 2018). Also, this propensity contributes to in-group favoritism, this is the proclivity to respond more positively to individuals from our ingroups than we do to individuals from outgroups (Hewstone, Rubin, & Willis, 2002; Stangor, Jhagiani, & Tarry, 2011). Therefore, according to SIT, individuals thus have an implicit tendency to fear out-groups and their members and to associate them through stereotypes with danger-connoting characteristics (Schaller & Neuberg, 2008).

Relying on this chain of reasoning, the present study focused on the perceived threat of disease, which has been found to predict heightened bias toward ethnic out-



groups (e.g. Aarøe, Osmundsen, & Petersen, 2016; Faulkner, Schaller, Park, & Duncan, 2004; Makhanova, Miller, & Maner, 2015). The central question in this context is why concerns about contagious diseases might contribute to individuals' bias toward people categorized as out-groups. Individuals who perceive threats of disease are motivated to avoid sick people, especially given cues to foreignness that trigger behavioral immune system responses such as avoidance, disgust, and physical distancing. These disease-avoidance mechanisms can play a role in prejudice against members of unfamiliar ethnic out-groups (Schaller et al., 2003). Specially because since individuals usually prefer to stay healthy, they choose to avoid interactions with others who appear to be physically sick (Crandall & Moriarty, 1995).

Building on these findings, the present study proposed that individuals may tend to distance themselves from outgroup members when the latter show symptoms of sickness. In the context of employee-customer interactions, we propose that minority employees' presenteeism behaviors may lead to greater levels of customers' fear of contagion when employees are demographically dissimilar to them. This fact may jeopardize customers perception of a quality service.

The Portuguese hospitality industry's workforce is characterized by diversity in terms of ethnicities and nationalities. The present study thus proposed that the fear of contagion associated with sickness presenteeism among demographically dissimilar individuals may also negatively influence customers' emotional and behavioral responses. These negative emotions can lead to less customer satisfaction and decreased customer loyalty, which may contribute to more unfavorable behavioral reactions such as negative WOM. As stated before, this may tend to occur due the customer perception of poor quality of service, even in the presence of one single service failure.

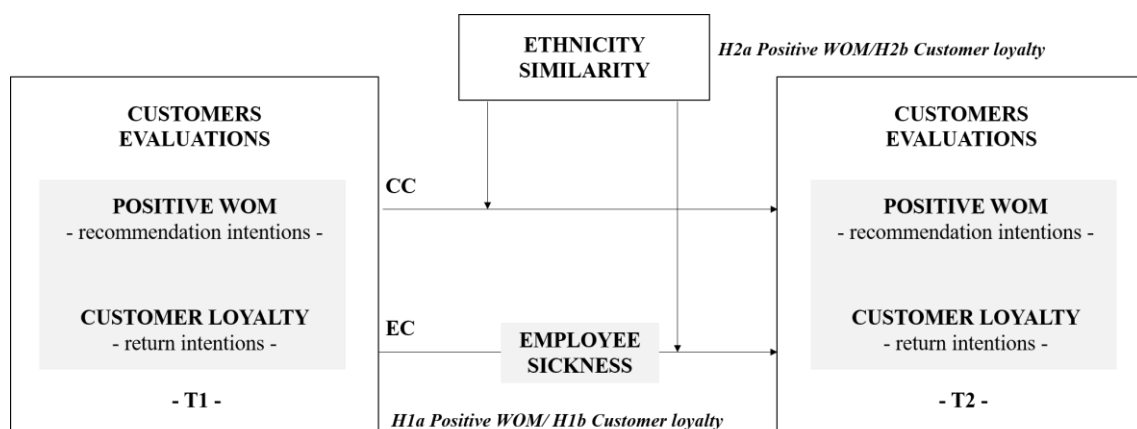
Thus, the following hypothesis was formulated for this research:

*Hypothesis 2a:* Employees' sickness and ethnicity impact the relationship between customers' recommendation intentions (i.e., to spread positive WOM) toward the tourist accommodation in question at T1 and customers' recommendation intentions toward the same tourist accommodation at T2.

More specifically, when employees show symptoms of sickness and when these individuals are dissimilar to customers in terms of ethnicity, customers will have weaker recommendation intentions toward the tourist accommodation in question. Thus, we further proposed the following hypothesis:

*Hypothesis 2b:* Employees' sickness and ethnicity impact the relationship between customers' return intentions toward the specific tourist accommodation in question at T1 and customers' return intentions toward the same tourist accommodation at T2.

Thus, when employees show symptoms of sickness and when these workers are dissimilar to customers in terms of ethnicity, the customers will have weaker return intentions toward the tourist accommodation in question. The research design and conceptual model of the above research hypotheses is presented in Figure 1.



*Note.* T1 = Time 1; T2 = Time 2; CC= control/no disease condition; EC=

experimental/disease condition.

Figure 1. *Proposed conceptual framework and quasi-experimental design.*

## Methodology

### Sample and procedures

This study sought to investigate the negative consequences of employees' sickness. A quasi-experimental approach was applied to determine how the presence of sick hospitality employees—versus the no disease group—affects customers' fear of contagion and intentions to recommend and/or return to stay in hotels. An example of the materials used is presented in Figure 2.



Figure 2. *Example of materials used in the disease and no disease conditions.*

To achieve our objectives, we collected data from 581 participants, recruited using convenience sampling with previous tourist accommodation experiences (i.e., in hotels or others similar).

The participants' mean ( $M$ ) age was 31 years old ( $M = 31.46$ ; standard deviation [ $SD$ ] = 13.13; minimum = 17; maximum = 79). Most participants (63.9%) have a higher education degree and Portuguese nationality (84.3%) and are Caucasian (93.1%). Regarding participants' tourist accommodation experience, most had stayed in hotels in Europe (80.2%). The type of travel reported most often was couples (32%) and families (29.4), and the average money spent on their last stay was €372.78 ( $SD = 634.78$ ). Table 2 shows the frequencies regarding the participants' distribution per condition (i.e., no disease vs. disease) and the scenarios' characteristics regarding ethnicity and job role.

Table 2. *Number of participants per condition.*

| <b>Condition</b>             | <b>Group</b> | <b><i>N</i></b> |
|------------------------------|--------------|-----------------|
| 1. Front Office Caucasian*   | No disease   | 30              |
| 2. Front Office Black**      | No disease   | 31              |
| 3. Front Office Brazilian*** | No disease   | 31              |
| 4. F&B Caucasian             | No disease   | 31              |
| 5. F&B Black                 | No disease   | 32              |
| 6. F&B Brazilian             | No disease   | 31              |
| 7. Housekeeping Caucasian    | No disease   | 30              |
| 8. Housekeeping Black        | No disease   | 33              |
| 9. Housekeeping Brazilian    | No disease   | 31              |

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|                            |         |     |
|----------------------------|---------|-----|
| 10. Front Office Caucasian | Disease | 36  |
| 11. Front Office Black     | Disease | 33  |
| 12. Front Office Brazilian | Disease | 34  |
| 13. F&B Caucasian          | Disease | 37  |
| 14. F&B Black              | Disease | 30  |
| 15. F&B Brazilian          | Disease | 34  |
| 16. Housekeeping Caucasian | Disease | 30  |
| 17. Housekeeping Black     | Disease | 34  |
| 18. Housekeeping Brazilian | Disease | 33  |
| <b>Total</b>               | Disease | 581 |

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*Note.* *N* = number; F&B = food and beverage; \* white employees; \*\* black employees;

\*\*\* Brazilian ancestry employees.

The data were collected using a self-report questionnaire in one of two versions—digitalized or paper—depending on the respondents' preference. The questionnaire started by asking respondents (i.e., T1) about their last tourist accommodation experience. More specifically, the item sought to determine how likely the respondents would be to (1) recommend that hotel to their families, friends, or colleagues and (2) return to stay in that accommodation facility.

Next, we controlled for the effects of three different jobs (i.e., hotel maid; cafe, bar, or restaurant attendant; and receptionist) and three different ethnicities and

nationalities (i.e., Brazilian ancestry, Caucasian/White, and Black). To this end, the questionnaire at Time 2 presented the employees' pictures to the respondents along with the following sentence: "Imagine that you encounter in your tourist accommodation [fictitious employee name], a [job role] employee." Since Brazilian nationality is more difficult to identify through an image, we added the employees' nationality to the picture descriptions.

In addition, we manipulated the employees' sickness-health features. In the disease group, the questionnaire informed the respondents that the employee presented symptoms of a severe cold by including the following description. "Imagine that you encounter in your tourist accommodation [fictitious employee name], a [job role] employee who appears to be tired, shows signs of fever, and often coughs and sneezes."

We sought to test for the possible effect of hotel employees' sickness symptoms (i.e., sickness presenteeism) on customers' intentions to recommend and return to the tourist accommodation in which they stayed. Thus, the respondents were asked a second time (i.e., T2) how likely they would be to recommend and return to that specific hotel. In total, the study involved nine different groups—each one with a no disease condition and a disease condition measured at T1 and T2.

To guarantee ethical research practices, this study complied with the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association (2010) and the Ordem dos Psicólogos Portugueses (Order of Portuguese Psychologists) (2011). Before filling out the questionnaire, respondents were provided with information about the research objectives, completion instructions, and voluntary participation and were assured of the confidentiality and anonymity of the data collected. The data were inserted in a database and analyzed using Statistical Package for the Social Sciences version 25.0.

### Scenarios test

To ensure that the images chosen to illustrate the different job roles and ethnicities and/or nationalities were neutral, this is, did not show any type of disease, we pre-tested all images with a small sample of respondents with similar characteristics to the overall sample. We collected data from 34 participants using an online self-report questionnaire.

Table 3. *N of respondents per condition and M and SD for evaluation of scenarios' neutrality.*

| <b>Scenarios</b>          | <b><i>N</i></b> | <b><i>M</i></b> | <b><i>SD</i></b> |
|---------------------------|-----------------|-----------------|------------------|
| 1. Front Office Caucasian | 34              | 1.94            | 1.278            |
| 2. Front Office Black     | 34              | 2.21            | 1.591            |
| 3. Front Office Brazilian | 34              | 1.91            | 1.401            |
| 4. F&B Caucasian          | 34              | 2.03            | 1.243            |
| 5. F&B Black              | 33              | 2.06            | 1.273            |
| 6. F&B Brazilian          | 33              | 2.06            | 1.171            |
| 7. Housekeeping Caucasian | 33              | 1.70            | 1.075            |
| 8. Housekeeping Black     | 33              | 1.64            | 1.168            |
| 9. Housekeeping Brazilian | 33              | 2.15            | 1.253            |

The respondents selected were presented, for each scenario, with the following sentence: “In terms of the employee’s state of health, this image suggests that this

person is . . .” The item was answered on a 7-point Likert-type scale (1 = “not sick at all”; 10 = “very sick”). The *M* value for all conditions is 1.97, which shows that the scenario pictures chosen to illustrate the different job roles and ethnicities and/nationalities are neutral, that is, do not depict any type of disease.

## **Instruments**

The questionnaire was based on self-report instruments developed to measure customer loyalty, positive WOM, and fear of contagion. These are described below in greater detail.

*Customer loyalty.* Customer loyalty was measured with one item adapted from the Net Promoter Score instrument developed by Reichheld (2003). The questionnaire asked respondents the following question: “How likely is it that you would return to stay in the tourist accommodation in which you stayed?” This item was answered on a 10-point Likert-type scale (1 = “Not likely”; 10 = “Very likely”).

*Positive WOM.* To measure positive WOM, one item was adapted from Reichheld’s (2003) Net Promoter Score instrument. The questionnaire asked participants the following question: “How likely is it that you would recommend the tourist accommodation in which you stayed to your families, friends, or colleagues?” This item was answered on a 10-point Likert-type scale (1 = “Not likely”; 10 = “Very likely”).

*Ethnicity similarity.* We created the variable of ethnicity similarity from the responses to the items on respondents’ ethnicity and from the information about the scenarios’ ethnicity. We then dummy coded ethnicity similarity as “0” to indicate a match in ethnicity between the respondent and the scenario ( $N = 167$ ) and as “1” to denote a mismatch ( $N = 183$ ). Demographic information was also collected, such as



customers' ethnicity, which was used to analyze employee-customer similarity and/or dissimilarity.

## Results

*Ms*, *SDs*, and correlations are presented in Table 4. The results show that positive WOM at T1 is positively related to customer loyalty at T1 ( $r = .783$ ;  $p < .01$ ) and positive WOM ( $r = .556$ ;  $p < .01$ ) and customer loyalty ( $r = .547$ ;  $p < .01$ ) at T2. Ethnicity similarity is only positively related to customer loyalty at T2 ( $r = .115$ ;  $p < .05$ ).

Table 4. *Descriptive statistics and correlations among studied variables.*

| Variables               | <i>N</i> | <i>M</i> | <i>SD</i> | Correlations |        |        |      |
|-------------------------|----------|----------|-----------|--------------|--------|--------|------|
|                         |          |          |           | 1            | 2      | 3      | 4    |
| 1. Positive WOM T1      | 581      | 7.83     | 2.17      |              |        |        |      |
| 2. Customer Loyalty T1  | 581      | 7.27     | 2.73      | .783**       |        |        |      |
| 3. Positive WOM T2      | 581      | 6.71     | 2.43      | .556**       | .520** |        |      |
| 4. Customer Loyalty T2  | 581      | 6.60     | 2.59      | .547**       | .663** | .857** |      |
| 5. Ethnicity Similarity | 350      | –        | –         | .079         | .045   | .115*  | .087 |

*Note.* \*\*  $p < .01$ ; \*  $p < .05$ .

### The impact of employee sickness on customers return and recommendation intentions

The main goal of this research was to examine the impact of employees' sickness on customers return (i.e., customer loyalty) and recommendation (i.e., positive WOM) intentions.

For this purpose, both dependent variables (customers return and recommendation intentions), measured on T1 and T2, were analyzed separately. Accordingly, we have conducted an analysis considering the design 2 (disease/no disease)  $\times$  2 (T1 vs. T2) repeated-measures ANOVA for each dependent variable.

Firstly, to test Hypothesis 1a, we sought to understand the relationship between the employees' sickness and customers' recommendation intentions (i.e., positive WOM) at T1 versus T2.

Results showed a main effect of employee sickness on customers' recommendation intentions (i.e., positive WOM) toward specific tourist accommodations ( $F_{(1, 579)} = 98.278; p < .001; \eta_{p^2} = .145$ ).

Figure 3 shows that, in both conditions (i.e., no disease *vs.* disease), participants tended to recommend their tourist accommodation more at T1 versus T2 ( $M_{T1CC} = 7.77$  *vs.*  $M_{T2CC} = 7.51$ ;  $M_{T1EC} = 7.89$  *vs.*  $M_{T2EC} = 5.97$ ). The difference between T1 and T2, however, is greater in the disease condition, namely, when the employees show symptoms of sickness (see Figure 3). This means that, when employees appear to be sick, customers tend to have weaker recommendation intentions toward the specific tourist accommodation in question. This result supports Hypothesis 1a, that is, that employees' sickness impacts the relationship between customers' recommendation intentions toward a tourist accommodation at T1 and customers' recommendation intentions toward the same company in T2.

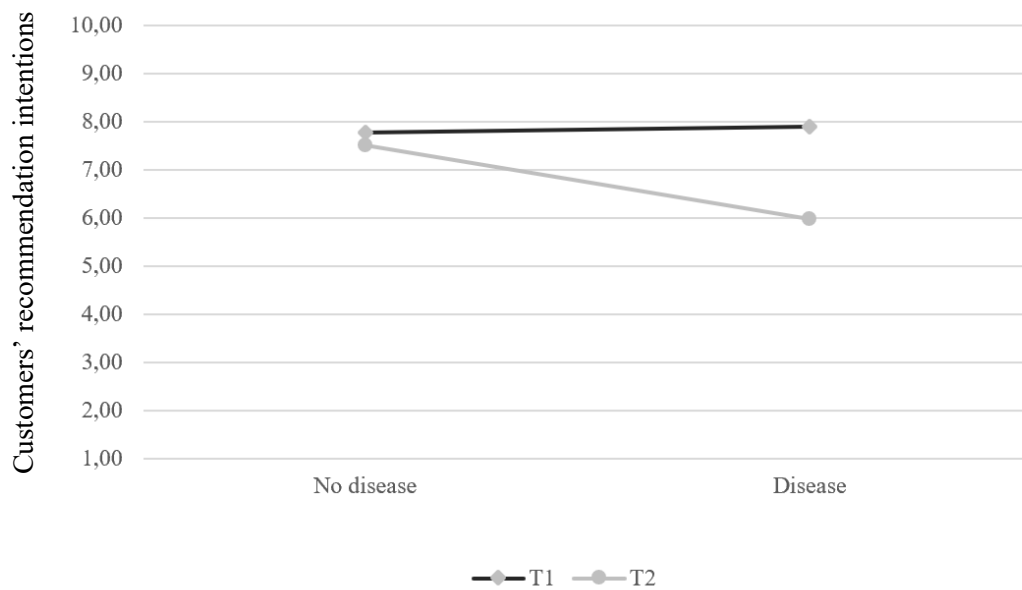


Figure 3. Main effect of employees' sickness (i.e. no disease vs. disease) on customers' recommendation intentions (i.e. positive WOM) at T1 versus T2.

Secondly, to test Hypothesis 1b, we examined the relationship between employees' sickness and customers' return intentions (i.e., customer loyalty) at T1 vs. T2. Results showed a main effect of employee sickness on customers' return intentions (i.e., customer loyalty) toward specific tourist accommodations ( $F_{(1, 579)} = 61.421$ ;  $p < .001$ ;  $\eta_p^2 = .096$ ).

Figure 4 shows that, in both conditions (i.e., no disease vs. disease), participants tended to plan to return more definitely to the tourist accommodation at T1 vs. T2 ( $M_{T1CC} = 7.25$  vs.  $M_{T2CC} = 7.28$ ;  $M_{T1EC} = 7.29$  vs.  $M_{T2EC} = 5.97$ ). However, the difference between T1 and T2 is greater in the disease condition, namely, when the employees' show symptoms of sickness (see Figure 4). This means that, when employees are sick, customers tend to have weaker return intentions toward the tourist accommodation in question. The results thus support Hypothesis 1b, that is, that employees' sickness impacts the relationship between customers' return intentions toward a specific tourist accommodation at T1 and customers' return intentions toward

the same tourist accommodation at T2.

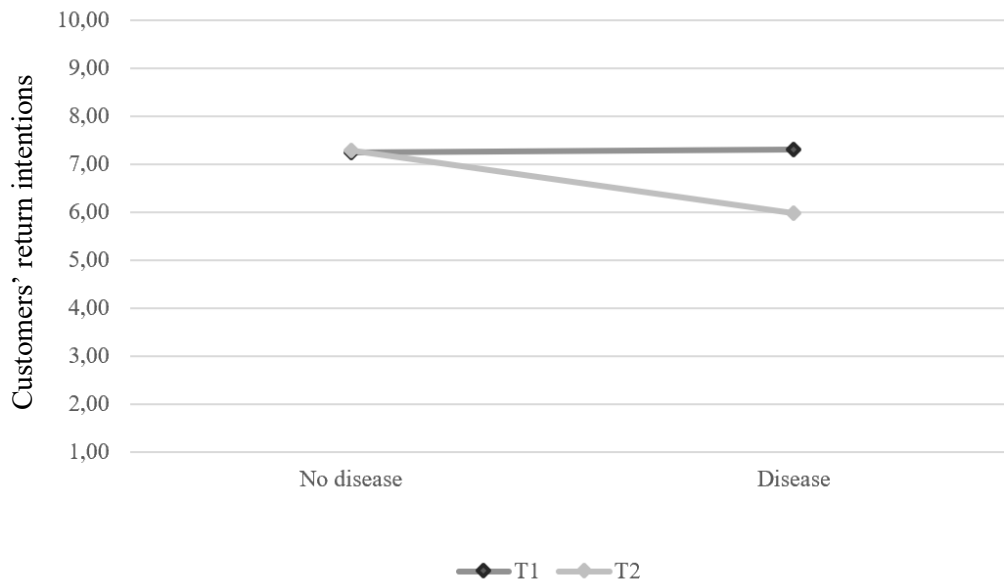


Figure 4. *Main effect of employees' sickness (i.e. no disease vs. disease) on customers' return intentions (i.e. customer loyalty) at T1 versus T2.*

### **The impact of employee sickness and ethnicity similarity on customers return and recommendation intentions**

Our second goal was to examine the impact of employees' sickness (disease *vs.* no disease) and ethnicity similarity (similar *vs.* non similar) on customers return and recommendation intentions (T1 *vs.* T2).

For this purpose, both dependent variables (customers return and recommendation intentions), measured on T1 and T2, were analyzed separately. Accordingly, we have conducted an analysis considering the design 2 (disease/no disease)  $\times$  2 (similar/non-similar)  $\times$  2 (T1 *vs.* T2) repeated-measures ANOVA for each dependent variable.

Thus, to test Hypothesis 2a, we sought to understand the relationship between employees' sickness, customers' recommendation intentions (i.e., positive WOM) at T1 vs. T2, and ethnicity similarity (i.e., similar vs. non-similar). The results reveal a main effect of employee sickness (no disease vs. disease) on customers' recommendation intentions (i.e., positive WOM) toward specific tourist accommodations based on a repeated measures ANOVA ( $F_{(1, 346)} = 50.602$ ;  $p < .001$ ;  $\eta_{p2} = .128$ ).

In addition, the results show a main effect of ethnicity similarity based on a repeated measures ANOVA ( $F_{(1, 346)} = 7.483$ ;  $p = .007$ ;  $\eta_{p2} = .021$ ).

Figure 5 reveals that, while under no disease conditions (i.e., when employees do not show any symptoms of sickness), participants present almost no difference between their intentions to recommend their accommodations at T1 vs. T2 for both similar ( $M_{T1} = 7.50$  vs.  $M_{T2} = 6.92$ ) and non-similar ethnicity conditions ( $M_{T1} = 7.92$  vs.  $M_{T2} = 8.10$ ). Otherwise, while in disease conditions (i.e., when employees appear to be sick), participants tend to have weaker recommendation intentions at T1 vs. T2 for both similar ( $M_{T1} = 7.56$  vs.  $M_{T2} = 6.10$ ) and non-similar ethnicity ( $M_{T1} = 7.83$  vs.  $M_{T2} = 6.03$ ) conditions.

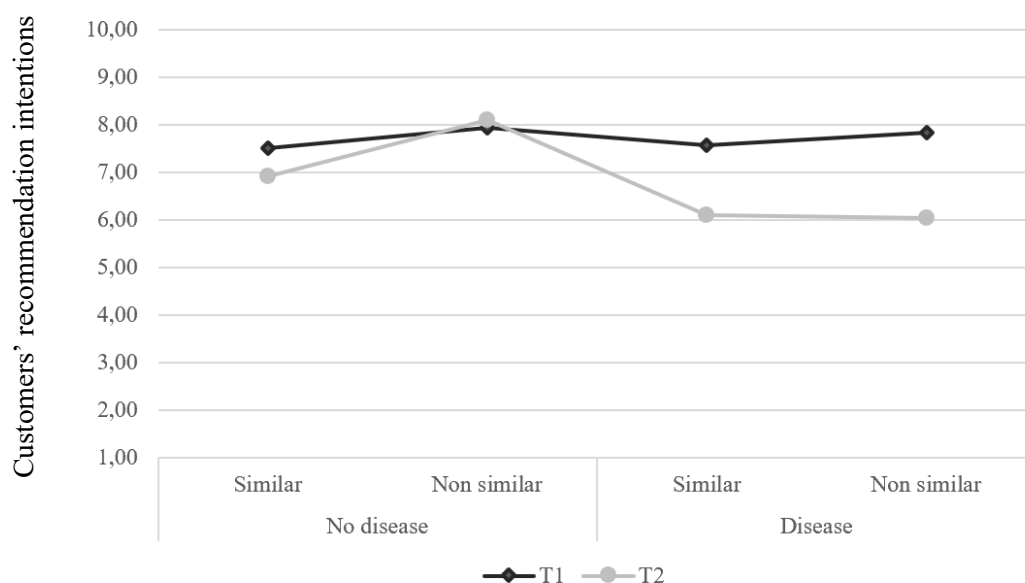


Figure 5. *Interaction effects of employees' sickness (no disease vs. disease), recommendation intentions (i.e. customer loyalty) at T1 vs. T2, and ethnicity similarity.*

A further analysis was carried out of these results using a repeated measures ANOVA ( $F_{(1, 171)} = .920$ ;  $p = .339$ ;  $\eta_{p2} = .005$ ) to test if there were significant differences between similar and non-similar ethnicity conditions when employees' were sick (i.e., for the disease condition). The results showed that the  $M$  differences between the similar and non-similar ethnicity disease conditions between T1 and T2 were not significant.

To test Hypothesis 2b, we examined the relationship between employees' sickness and customers' return intentions at T1 vs. T2 and for ethnicity similarity (i.e., similar vs. non-similar).

The results reveal a main effect of employee sickness (no disease vs. disease) on customers' return intentions (i.e., customer loyalty) toward specific tourist accommodations based on a repeated measures ANOVA ( $F_{(1, 346)} = 31.108$ ;  $p < .001$ ;  $\eta_{p2} = .082$ ).

However, the results did not show a main effect of ethnicity similarity ( $F_{(1, 346)} = .914$ ;  $p = .340$ ;  $\eta_{p2} = .003$ ). In addition, the interaction effect between employees' sickness, customers' return intentions at T1 vs. T2, and ethnicity similarity is not significant ( $F_{(1, 346)} = .919$ ;  $p = .339$ ;  $\eta_{p2} = .003$ ).

As can be seen in Figure 6, in no disease conditions (i.e., when employees do not display any symptoms of sickness), participants show almost no difference between their intentions to return to an accommodation at T1 vs. T2 for both similar ( $M_{T1} = 6.88$  vs.  $M_{T2} = 6.79$ ) and non-similar ethnicity conditions ( $M_{T1} = 7.50$  vs.  $M_{T2} = 7.81$ ). In contrast, in disease conditions (i.e., when employees appear to be sick), participants



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|                                     |              |      |      |      |      |      |      |      |      |
|-------------------------------------|--------------|------|------|------|------|------|------|------|------|
| <b>No Disease</b>                   |              | 7.77 | 2.16 | 7.51 | 2.21 | 7.25 | 2.71 | 7.28 | 2.47 |
| <b>Disease</b>                      |              | 7.89 | 2.17 | 5.97 | 2.39 | 7.29 | 2.76 | 5.97 | 2.54 |
| <b>Total</b>                        |              | 7.83 | 2.17 | 6.71 | 2.43 | 7.27 | 2.73 | 6.60 | 2.59 |
| <br>                                |              |      |      |      |      |      |      |      |      |
| <b>Ethnicity Similarity (N=350)</b> |              |      |      |      |      |      |      |      |      |
|                                     | No disease   | 7.92 | 2.20 | 8.10 | 1.90 | 7.50 | 2.65 | 7.81 | 2.27 |
| <b>Non-Similar</b>                  | Disease      | 7.83 | 2.26 | 6.03 | 2.27 | 7.04 | 2.90 | 5.96 | 2.38 |
|                                     | <i>Total</i> | 7.87 | 2.23 | 7.06 | 2.33 | 7.27 | 2.78 | 6.88 | 2.50 |
|                                     | No disease   | 7.50 | 2.27 | 6.92 | 2.35 | 6.88 | 2.78 | 6.79 | 2.51 |
| <b>Similar</b>                      | Disease      | 7.56 | 2.10 | 6.10 | 2.28 | 7.16 | 2.73 | 6.07 | 2.42 |
|                                     | <i>Total</i> | 7.53 | 2.18 | 6.52 | 2.35 | 7.02 | 2.75 | 6.44 | 2.48 |
|                                     | No disease   | 7.72 | 2.24 | 7.53 | 2.20 | 7.20 | 2.72 | 7.32 | 2.44 |
| <b>Total</b>                        | Disease      | 7.70 | 2.18 | 6.06 | 2.27 | 7.10 | 2.82 | 6.01 | 2.39 |
|                                     | <i>Total</i> | 7.71 | 2.21 | 6.80 | 2.35 | 7.15 | 2.76 | 6.67 | 2.50 |

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## Discussion

This research was designed to answer the question: Do hotel employees' sickness and ethnicity affect customers' loyalty and positive WOM? We focused essentially on the Portuguese tourism sector, due to its current worldwide economic importance and visibility (Ferreira, et al., 2017) and because it is a sector with high demands in terms of human resource practices and evident presenteeism cultures/climates (Deery & Jago, 2009).

As expected, the results confirm that employees' sickness impacts the relationship between customers' recommendation intentions (i.e., to spread positive WOM) toward specific tourist accommodations at T1 and their recommendation intentions toward the same tourist accommodations at T2. This means that, when employees appear to be sick, customers tend to have weaker recommendation intentions (i.e., to spread positive WOM) toward specific tourist accommodations compared to when employees appear healthy.

Similarly, the results reveal that employees' sickness also impacts the relationship between customers' return intentions toward certain tourist accommodations at T1 and customers' return intentions toward the same tourist accommodations at T2. Thus, when employees show symptoms of sickness, customers tend to have weaker return intentions (i.e., less customer loyalty) toward particular tourist accommodations compared to when employees do not appear to be sick. These results support both Hypothesis 1a and Hypothesis 1b.

Our findings show that individuals are alert to cues in the environment that signal the possible presence of disease. During service co-production, customers are aware of employees' sickness symptoms which not only threatens their health (Luksyte et al., 2015) but also defrauds their expectation of a quality service. According to the

present study's results, customers not only tend to avoid hotels that endanger their health and fail to provide a quality service, but also, they tend to prevent others from encountering the same situation by developing weaker recommendation intentions. Thus, our findings suggest that employees' presenteeism behaviors have a potentially negative effect for hotels' success, since they decrease customers' loyalty and intentions to spread positive WOM. Undeniably, this indicates that when hotels fail to provide key features of quality service such as safety and security (Hemmington, 2007), they are threatening their own success by allowing their employees to work while feeling sick. Hence, we state that presenteeism behaviors in the hospitality industry may have a potentially negative effect on hotels profitability.

Our results also revealed significant effects that support that employees' sickness and ethnicity impact the relationship between customers' recommendation intentions (i.e., to spread positive WOM) toward specific tourist accommodations at T1 and customers' recommendation intentions toward the same tourist accommodations at T2. Nonetheless, it's important to notice that the present study shows an effect size near zero when we include ethnicity similarity variable, which may mean that even though our hypothesized relationship (H2a) is statistically significant, it may not have readily observable impacts in real life. This conclusion is crucial since Cohen (1992) highlights the importance of reporting and analyzing effect sizes to assess the practical significance of results, this is what are the practical consequences of the findings for daily life. Indeed, according to Lakens (2013), effect sizes are a very useful outcome of empirical studies since researchers aim to understand whether an intervention or experimental manipulation has an effect greater than zero and how big the effect is. This being said, our supplementary analysis' results revealed that when employees show sickness symptoms, participants present no significant differences between their

intentions to recommend touristic accommodations at T1 vs. T2 regardless of employees' ethnicity. Due to this fact we rejected Hypothesis 2a.

Also, hypothesis 2b was not supported. The results did not show that employees' sickness and ethnicity impact the relationship between customers' return intentions toward specific tourist accommodations at T1 and these individuals' return intentions toward the same tourist accommodations at T2. Therefore, when employees both engage in sickness presenteeism and come from dissimilar ethnic groups, customers do not show weaker return intentions toward the tourist accommodations compared to when these customers are similar to employees in terms of ethnicity.

Henceforth, our results refute previous studies that defend that perceived threats of disease foresee heightened bias toward ethnic out-groups (e.g., Makhanova et al., 2015) and in-group favoritism (Navarrete & Fessler, 2006). Overall this evidence suggests that ethnicity-related dissimilarities between customers and hotel employees may not enhance customers' tendency to recommend and rebook a hotel less often when employees present sickness presenteeism behaviors. In other words, results show that sickness symptoms per se may have such a strong negative effect on the customer that they render the effect of ethnic dissimilarities negligible or even inexistent.

### **Theoretical and practical contributions**

Firstly, our research adds to the marketing field by showing that customer loyalty and positive WOM have an important role for hospitality companies. This happens mainly because brand or company loyalty, defined as having a positive attitude toward the company brand (Yi & Jeon, 2003), it's dependent on customers' emotional states, since it incorporates the underlying psychological state that reflects the affective nature of the relationship between the individual customer and the provider, leading to favorable attitudes (Gundlach, Archol &, Mentzer, 1995).

Accordingly, our results show that the perceived quality of the relationship between a customer and a company can be harmed when company employees are sick, leading to weaker return and recommendation intentions toward tourist accommodations. This may happen not only because customers try to escape or distance themselves from a source of infection (Luksyte et al., 2015), but mainly because they are compensating themselves for the hotel service failure. In fact our findings showed us that customers' expectations of a quality service are endangered when they have to deal with noticeably sick employees, especially because they feel defrauded by the company not providing them valued and expected aspects of hotel services such as quality staff and service, and safety and security (e.g., Callan & Bowman, 2000; Hemmington, 2007; Lockyer, 2002).

This evidence is crucial to hospitality companies since gaining customer loyalty is an important goal of marketing strategies in order to retain and hold their customers (Aksoy, 2013). Nonetheless, it is a prime concern that companies make conscious efforts to optimize their investments in customers' loyalty. And to do so they need to be aware of the potential vulnerabilities in loyalty formation and the importance of sustaining service quality throughout the customers stay in order to maintain their loyalty.

Secondly, the present study enriches the literature on sickness presenteeism in various ways. First, our research produced significant findings that add to the scarce literature on presenteeism in the hospitality sector. According to Martinez and Ferreira (2012), presenteeism is particularly prevalent in the education and welfare and health sectors. Researchers also acknowledge that hospitality and tourism organizational cultures promote presenteeism behaviors (Deery & Jago, 2009) due to inherent job characteristics and demands. Also, it extends the existing literature (e.g., Arslaner & Boylu, 2017) providing a broad perspective on sickness presenteeism, by focusing on

the consequences of this organizational phenomena at the organization level, rather only on the individual level. Plus, it demarks itself from the extant research, by using a quasi-experimental design to explore our proposed hypothesis.

Thirdly, to our knowledge, this study is the first to explore the relationship between sickness presenteeism and customer loyalty and positive WOM in terms of ethnicity (i.e., similar and non-similar) scenarios. Accordingly, this study included patterns that are congruent with SIT (Tajfel & Turner, 1979). Still, as mentioned before, in our study the effect size of the main effect of ethnicity similarity is rather small. Indeed, although customers' withdrawal from out-groups showed to be more apparent when employees presented sickness presenteeism behaviors, our supplementary analysis showed that there were no significant differences between ethnicity conditions in both T1 vs. T2. Overall, our results lead us to assume that our hypothesized relationship (H2a) although its statistical significance, may not have readily observable impacts in real life (Lakens, 2013).

Fourthly, this research also has important implications for hotel managers and human resources directors (HRD). More specifically, comprehensive scenarios were examined of how customers react to hospitality employees' sickness. Therefore, the findings provide information for managers and HRD regarding the potentially negative effects of sickness presenteeism and its threat to the perceived quality of hotel services. Our study highlights the importance of sustaining service quality throughout customers stays for maintaining their loyalty, showing that guests might not be willing to return and recommend a touristic accommodation after having encountered one single service failure, associated to employees' ill health. For this reason, to avoid the negative organizational consequences of sickness presenteeism, hotel board teams need to be prepared to anticipate, diagnose, and manage patterns of sickness presenteeism to

generate more positive organizational outcomes.

### **Limitations and future studies**

These findings should be interpreted with the following limitations in mind. The first limitation is related to the sample size as data on a larger group of participants would have provided more conclusive results. Future studies could benefit from replicating this research with a more representative sample, as well as a greater range of individuals from other populations with diverse cultural backgrounds, to increase this study's external validity and to improve understandings of presenteeism in the hospitality literature (Chia & Chu, 2017).

Replicating this research with scenarios from other ethnicities and nationalities could also produce interesting results. Moreover, future studies may consider other types of hotels and how different related-variables (e.g. luxury, budget, location) influence the studied hypotheses.

We also point as a limitation the absence of manipulation checks in this study. Future studies could add manipulation checks and qualitative methodologies to verify the participants' interpretation of the customer's ill health. This manipulation check may enable researchers to understand if customers have interpreted the sick employee presence as a sign of poor service quality due to deficient occupational health and safety policies and inefficient or absence of sustainable Human Resource Management (HRM) practices.

Despite these limitations, the present study's findings provide novel insights into sickness presenteeism by gaining a deeper understanding of how it affects the hospitality industry. The findings shed further light on presenteeism's negative outcomes for the tourism and travel sectors. These results thus enhance the existing literature on this subject, which, until now, has mostly focused on other sectors such as

education, health, and welfare.

### **Conclusion**

This study is among the first to investigate the association between sickness presenteeism and both customer loyalty and positive WOM in the hospitality sector. Our findings answer recent calls (e.g., Arslaner & Boylu, 2017) for research about the cost of presenteeism to organizations, suggesting that, when hospitality employees show symptoms of sickness, customers tend to have weaker recommendation and return intentions toward their hotels compared to when employees do not appear to be sick. This fact is intimately related to perceived service failures in terms of valued and expected aspects of hotel services such as quality staff and service, safety and security. In addition, our results show that due to perceived ethnic dissimilarity, customers do not tend to withdraw from non-similar sick employees, not showing weaker recommendation and rebooking intentions toward tourist accommodations.

Overall, our findings indicate that when hotel employees go to work despite being sick the losses faced will be not only at the individual level (e.g., compromised health and performance) but also at the organizational level since sick employees are unable to maintain an adequate level of service which lead to negative perceptions of service quality and brand image, as well as decreased customer loyalty.

This research adds to the very well-established literature on consumer-brand relationships and marketing, sickness presenteeism and social cognition, highlighting the need to diagnose and manage these behaviors in order to achieve organizational advantages.

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