Customer Care, Response Experience and Reasons for Client Retention at Lubaga Hospital, Uganda

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ABSTRACT

Patients may forgive an old building before they forgive being ignored, delayed or poorly informed. In health care, interpersonal treatment becomes part of the clinical experience because vulnerability amplifies the meaning of respect, responsiveness and communication. Retention is therefore often decided in ordinary encounters: whether someone listened, explained, coordinated and treated the patient as a person. This article integrates the quantitative customer-care objective with the qualitative inquiry into why clients return to, or avoid returning to, Lubaga Hospital. Methodologically, the cross-sectional mixed-methods study analysed 107 usable questionnaires and 24 completed qualitative interviews using descriptive statistics, Pearson correlation, multiple regression and content analysis. Customer care averaged 3.94 (SD = .66 in the correlation table) and was positively associated with retention ($r = .276$, $p = .004$). In the multivariable model it was the only reported predictor to remain statistically significant at the .05 level ($B = .231$, $\beta = .237$, $p = .016$). Qualitative accounts identified clear communication, empathy, personalised attention, listening by doctors, coordinated care, professionalism, advanced facilities and trust as reasons for return, while delays, administrative difficulty, communication gaps and perceived unprofessionalism contributed to non-return. The article argues that retention is produced through a patient journey rather than a single transaction.

Keywords: customer care; patient experience; response time; client retention; communication; qualitative evidence; Uganda

INTRODUCTION

Customer care in healthcare includes more than courtesy. It is the operational expression of respect through timely attention, clear information, listening, coordination, complaint handling and the reduction of unnecessary patient effort. These behaviours matter because healthcare encounters are emotionally charged and information-asymmetric; the patient often evaluates organisational trustworthiness through staff behaviour long before being able to judge technical clinical quality. Studies of patient satisfaction, relationship management and service encounters consequently place communication, empathy and responsiveness near the centre of loyalty formation (Abekah-Nkrumah et al., 2021; Gudergan et al., 2008; Koca & Erigüç, 2020; Mangus et al., 2020; Spicuzza, 1992; Torres & Zhang, 2022) (Abekah-Nkrumah et al., 2021; Alam et al., 2021; Han & Hyun, 2015; Kwiatek et al., 2020; Payne & Frow, 2016; Vaniara & Pramono, 2022).

The Lubaga Hospital data provide a useful test of this proposition. Customer care showed the strongest independent coefficient among the three reported predictors, and the qualitative strand supplied concrete explanations for return and non-return. This mixed pattern permits a stronger analytical claim than correlation alone: the statistical association has plausible behavioural mechanisms visible in patients' narratives. Article 1 and Article 2 should therefore be read as complementary evidence showing that loyalty initiatives and service quality are most likely to retain patients when converted into a coherent interpersonal and process experience (Abekah-Nkrumah et al., 2021; Gudergan et al., 2008; Koca & Erigüç, 2020; Mangus et al., 2020; Spicuzza,

1992; Torres & Zhang, 2022) (Aburayya et al., 2020; Akdere et al., 2020; Amporfro et al., 2021; Han & Hyun, 2015; Higenyi, 2020; Venetis & Ghauri, 2004).

THEORETICAL FRAMEWORK

Customer Service Theory explains retention through the organisation's capacity to meet or exceed expectations consistently; Social Penetration Theory adds the idea that repeated, reciprocal and trustworthy communication deepens relationships; the Johari Window highlights feedback, disclosure and organisational self-awareness. Combined, these perspectives explain why listening and explanation can be strategically consequential in health care: communication reduces uncertainty, feedback reveals hidden service failures, and respectful interaction creates relational confidence. Contemporary relationship-marketing evidence similarly links communication quality and trust to loyalty outcomes (Abekah-Nkrumah et al., 2021; Gudergan et al., 2008; Koca & Erigüç, 2020; Mangus et al., 2020; Spicuzza, 1992; Torres & Zhang, 2022) (Abekah-Nkrumah et al., 2021; Alam et al., 2021; Han & Hyun, 2015; Kwiatek et al., 2020; Payne & Frow, 2016; Vaniara & Pramono, 2022).

The theoretical implication is that customer care is both a distinct construct and a transmission mechanism. It is distinct because patients directly evaluate responsiveness, respect and waiting experience; it is a mechanism because these encounters convert technical service delivery into satisfaction, trust and intention to return. This helps explain why customer care retained significance in the joint regression while service quality became less precise and loyalty programmes remained weak. In other words, the human interface may be where otherwise valuable quality and loyalty investments become psychologically meaningful (Abekah-Nkrumah et al., 2021; Gudergan et al., 2008; Koca & Erigüç, 2020; Mangus et al., 2020; Spicuzza, 1992; Torres & Zhang, 2022) (Aburayya et al., 2020; Akdere et al., 2020; Amporfro et al., 2021; Han & Hyun, 2015; Higenyi, 2020; Venetis & Ghauri, 2004) (Abekah-Nkrumah et al., 2021; Alam et al., 2021; Han & Hyun, 2015; Kwiatek et al., 2020; Payne & Frow, 2016; Vaniara & Pramono, 2022).

Table 1. Customer-care mechanisms linked to return and non-return

Customer-care domain	Positive retention mechanism	Potential non-return trigger	Management metric
Responsiveness	Prompt attention lowers effort and anxiety	Long waits; unanswered queries	Time-to-first-response; cycle time
Communication	Clear explanation builds confidence	Information gaps; conflicting messages	Comprehension/communication score
Empathy/listening	Patient feels recognised and respected	Dismissive or impersonal interaction	Patient-reported empathy
Coordination	Smooth hand-offs support continuity	Administrative difficulty; fragmented processes	Handover failures; repeat contacts
Professionalism	Signals competence and integrity	Perceived unprofessional conduct	Complaints; service-recovery closure

METHODOLOGY

The article is derived from a cross-sectional mixed-methods study undertaken at Lubaga Hospital. Of 148 questionnaires distributed, 107 were usable; 24 of 32 planned qualitative interviews were completed. Quantitative analysis used descriptive statistics, Pearson correlation and multiple regression, while qualitative accounts were examined through content analysis to identify recurring explanations for favourable and unfavourable return intentions. The methodological value of this design is complementarity: coefficients estimate the pattern of association, while qualitative evidence helps identify mechanisms and contextual meanings that a numerical scale cannot fully represent (Krejcie & Morgan, 1970; Roberts & Priest, 2006; Wang & Cheng, 2020; Amporfro et al., 2021; Akdere et al., 2020) (Abekah-Nkrumah et al., 2021; Gudergan et al., 2008; Koca & Erigüç, 2020; Mangus et al., 2020; Spicuzza, 1992; Torres & Zhang, 2022).

Interpretation follows a convergence logic. A quantitative finding is treated as more persuasive when qualitative accounts describe mechanisms consistent with the statistical direction; divergence is treated as a signal for refinement rather than discarded. This is particularly important for customer care because the same waiting time, staff encounter or explanation can have different meanings across patients depending on expectations and clinical circumstances. Accordingly, the qualitative material is used analytically to explain heterogeneity and to generate testable service-improvement propositions, not merely as illustrative quotation (Krejcie & Morgan, 1970; Roberts & Priest, 2006; Wang & Cheng, 2020; Amporfro et al., 2021; Akdere et al., 2020) (Abekah-Nkrumah et al., 2021; Gudergan et al., 2008; Koca & Erigüç, 2020; Mangus et al., 2020; Spicuzza, 1992; Torres & Zhang, 2022).

RESULTS

Table 2. Descriptive customer-care/response indicators

Customer-care indicator	Mean	SD	Interpretation
Response time to customer queries attracts new customers	4.07	1.18	Agree
Response time influences retention	3.93	1.29	Agree
Employees value customer time and reduce service time	3.79	1.32	Agree
Employees need training to reduce total service time	3.93	1.25	Agree
Streamlining service processes can reduce service time	3.94	1.26	Agree
Employee appearance influences retention	3.99	1.22	Agree
Global mean	3.94	1.25	Agree

Table 3. Correlation between customer care and retention

Variable	Mean	SD	r with retention	p	Interpretation
Customer care	3.9424	.65920	.276	.004	Positive and statistically significant
Customer retention	4.0327	.64364	1.000	—	Outcome variable

Table 4. Adjusted regression coefficients

Predictor	B	SE	B	T	p	Interpretation
Loyalty programmes	.083	.063	.124	1.332	.186	Not significant
Service quality	.200	.106	.182	1.884	.062	Positive; not significant at .05
Customer care	.231	.095	.237	2.439	.016	Positive and significant

Table 5. Qualitative themes on return and non-return

Reasons encouraging return	Reasons discouraging return
Clear communication and explanation	Communication gaps or inconsistent information
Empathy, personalised attention and listening	Perceived unprofessional or dismissive behaviour
Coordinated care and confidence in clinicians	Administrative difficulty and fragmented processes
Advanced facilities and perceived competence	Delays and excessive service time
Trust and positive prior experience	Dissatisfaction with service processes

Quantitatively, customer care had a positive, statistically significant correlation with retention ($r = .276$, $p = .004$) and remained significant in the joint regression ($B = .231$; $\beta = .237$; $p = .016$). Unlike the loyalty-programme result in Article 1 and the attenuated service-quality result in Article 2, this association persisted

after simultaneous adjustment. The qualitative themes in Table 5 provide convergent explanation: patients described return decisions in terms of communication, empathy, clinician attention, coordination and trust, while non-return narratives emphasised delays, administrative friction, information problems and perceived unprofessionalism (Abekah-Nkrumah et al., 2021; Gudergan et al., 2008; Koca & Erigüç, 2020; Mangus et al., 2020; Spicuzza, 1992; Torres & Zhang, 2022) (Abekah-Nkrumah et al., 2021; Alam et al., 2021; Han & Hyun, 2015; Kwiatek et al., 2020; Payne & Frow, 2016; Vaniara & Pramono, 2022).

ANALYTICAL DISCUSSION

5.1 Customer care as the operational face of institutional trust

The persistence of customer care in the adjusted model suggests that interpersonal and process experience carries unique information beyond the more general service-quality construct. This is plausible because patients encounter the institution through people and hand-offs: registration, triage, consultation, diagnostics, pharmacy, billing and follow-up. Each touchpoint can either confirm or undermine confidence. Repeated respectful encounters create predictability and relational security, while repeated friction can erode trust even when clinical infrastructure is strong (Abekah-Nkrumah et al., 2021; Gudergan et al., 2008; Koca & Erigüç, 2020; Mangus et al., 2020; Spicuzza, 1992; Torres & Zhang, 2022) (Abekah-Nkrumah et al., 2021; Alam et al., 2021; Han & Hyun, 2015; Kwiatek et al., 2020; Payne & Frow, 2016; Vaniara & Pramono, 2022).

5.2 Response time as both efficiency and respect

Waiting and response time should not be treated solely as operations metrics. For patients, delay can communicate disorganisation, low priority or lack of empathy, particularly when no explanation is provided. Conversely, timely acknowledgement can protect satisfaction even when unavoidable clinical waits remain. This interpretation links process engineering to communication: hospitals can improve perceived responsiveness both by reducing actual cycle time and by managing expectations transparently, updating patients and designing escalation routes for unresolved queries (Abekah-Nkrumah et al., 2021; Gudergan et al., 2008; Koca & Erigüç, 2020; Mangus et al., 2020; Spicuzza, 1992; Torres & Zhang, 2022) (Aburayya et al., 2020; Akdere et al., 2020; Amporfro et al., 2021; Han & Hyun, 2015; Higenyi, 2020; Venetis & Ghauri, 2004).

5.3 Why clients do not return: a friction accumulation model

The qualitative findings imply that non-return can result from accumulated friction rather than one catastrophic failure. Administrative complexity, repeated delays, poor explanation and unprofessional interactions can compound across a patient journey until the perceived cost of returning exceeds the value of familiarity. This accumulation model explains why isolated loyalty incentives may have little effect: a reward cannot compensate for repeated uncertainty or disrespect. It also explains why service recovery and complaint management should be treated as retention interventions rather than peripheral public-relations activities (Abekah-Nkrumah et al., 2021; Gudergan et al., 2008; Koca & Erigüç, 2020; Mangus et al., 2020; Spicuzza, 1992; Torres & Zhang, 2022) (Abekah-Nkrumah et al., 2021; Alam et al., 2021; Han & Hyun, 2015; Kwiatek et al., 2020; Payne & Frow, 2016; Vaniara & Pramono, 2022) (Alshurideh et al., 2020; Fook & Dastane, 2021; Hofman-Kohlmeyer, 2016; Khairawati, 2020; Magatef & Tomalieh, 2015; Watson et al., 2015).

INTEGRATED IMPLICATIONS FOR LUBAGA HOSPITAl

The three extracted studies point toward one integrated management priority: design the patient journey around continuity, reliability and relational confidence. Loyalty programmes should support follow-up and recognition (Article 1); service quality should integrate technical assets with reliable processes (Article 2); and customer care should ensure timely, respectful and well-coordinated encounters (this article). The combined model is stronger than any isolated intervention because it treats retention as an emergent outcome of multiple mutually reinforcing experiences (Alshurideh et al., 2020; Fook & Dastane, 2021; Hofman-Kohlmeyer, 2016; Khairawati, 2020; Magatef & Tomalieh, 2015; Watson et al., 2015) (Aburayya et al., 2020; Akdere et al., 2020; Amporfro

et al., 2021; Han & Hyun, 2015; Higenyi, 2020; Venetis & Ghauri, 2004) (Abekah-Nkrumah et al., 2021; Gudergan et al., 2008; Koca & Erigüç, 2020; Mangus et al., 2020; Spicuzza, 1992; Torres & Zhang, 2022).

Operationally, Lubaga Hospital could implement a patient-experience dashboard that combines waiting time, unanswered-query rate, complaint-resolution time, patient-reported empathy, communication clarity, repeat-visit rate and reasons for defection. Qualitative exit interviews or short digital follow-ups should be routinely analysed for recurring friction points, while staff coaching should use actual patient-journey failures rather than generic customer-service slogans. Such a closed feedback loop operationalises the Johari Window emphasis on reducing organisational blind spots and aligns relationship management with continuous quality improvement (Abekah-Nkrumah et al., 2021; Gudergan et al., 2008; Koca & Erigüç, 2020; Mangus et al., 2020; Spicuzza, 1992; Torres & Zhang, 2022) (Abekah-Nkrumah et al., 2021; Alam et al., 2021; Han & Hyun, 2015; Kwiatek et al., 2020; Payne & Frow, 2016; Vaniara & Pramono, 2022).

LIMITATIONS AND FUTURE RESEARCH

The study is limited by its cross-sectional design, self-report measures, single-site setting and the absence of longitudinal behavioural retention records. The qualitative sample provides depth but not statistical representativeness, and the reported themes should therefore be interpreted as explanatory patterns rather than prevalence estimates. Future research should link patient-experience surveys to verified repeat utilisation, model waiting time and communication separately, test mediation through satisfaction and trust, and compare patient segments and service lines (Krejcie & Morgan, 1970; Roberts & Priest, 2006; Wang & Cheng, 2020; Amporfro et al., 2021; Akdere et al., 2020) (Abekah-Nkrumah et al., 2021; Gudergan et al., 2008; Koca & Erigüç, 2020; Mangus et al., 2020; Spicuzza, 1992; Torres & Zhang, 2022).

CONCLUSION

Customer care was the clearest independent retention predictor in the reported Lubaga Hospital model, and the qualitative evidence explains why: patients return where they feel heard, informed, respected and competently guided through care. The implication is not that equipment, quality systems or loyalty programmes are unimportant; rather, their retention value is realised through the patient's lived journey. A professional retention strategy should therefore convert technical capability into humane, responsive and coordinated experience at every touchpoint (Abekah-Nkrumah et al., 2021; Gudergan et al., 2008; Koca & Erigüç, 2020; Mangus et al., 2020; Spicuzza, 1992; Torres & Zhang, 2022) (Aburayya et al., 2020; Akdere et al., 2020; Amporfro et al., 2021; Han & Hyun, 2015; Higenyi, 2020; Venetis & Ghauri, 2004) (Abekah-Nkrumah et al., 2021; Alam et al., 2021; Han & Hyun, 2015; Kwiatek et al., 2020; Payne & Frow, 2016; Vaniara & Pramono, 2022).

RECOMMENDATIONS

The results of this article demonstrated that customer care had a positive and statistically significant relationship with client retention ($r = .276$, $p = .004$). More importantly, customer care remained statistically significant after loyalty programmes and service quality were entered simultaneously into the regression model ($\beta = .237$, $p = .016$), making it the strongest independent predictor among the three customer-satisfaction strategies examined. The qualitative findings further identified communication, empathy, personalised attention, professional conduct, coordinated care and trust as reasons patients were willing to return, while delays, administrative difficulties, perceived unprofessionalism and communication gaps contributed to intentions not to return. The recommendations therefore prioritise relational and organisational aspects of patient experience.

First, Lubaga Hospital should elevate customer care from an individual staff responsibility to an institution-wide patient-experience strategy. Because customer care remained independently associated with retention after controlling for the other predictors, all departments should recognise that every interaction with the patient contributes to the likelihood of future utilisation. Receptionists, nurses, doctors, laboratory personnel, pharmacy staff, cashiers, security personnel and administrators should therefore operate under common patient-care standards.

Second, the hospital should strengthen continuous training in effective communication, empathy, listening and professional conduct. The qualitative findings indicate that patients value being listened to, respected and adequately informed. Training should emphasise explaining diagnoses and procedures in understandable language, managing expectations, responding respectfully to concerns, maintaining confidentiality and communicating delays whenever they occur.

Third, Lubaga Hospital should establish clear patient-response-time standards across the entire care pathway. The quantitative findings showed that respondents attached considerable importance to timely responses, while qualitative accounts identified delays as one of the reasons patients may not return. Management should therefore define acceptable turnaround times for registration, consultation, investigations, pharmacy services, billing, complaint resolution and response to patient inquiries.

Fourth, management should strengthen care coordination and navigation, particularly for patients requiring several departments during a single episode of care. Patients should not be expected to independently navigate complex administrative processes. Patient navigators, customer-care officers or clearly designated service coordinators could assist vulnerable patients, older persons, international patients and those requiring multidisciplinary care.

Fifth, Lubaga Hospital should develop a robust complaint and service-recovery system. Dissatisfaction does not inevitably result in permanent patient loss when complaints are acknowledged promptly and corrected appropriately. Complaints should therefore be recorded, categorised, investigated and resolved within defined timelines. Where service failure occurs, staff should be empowered to apologise appropriately, explain corrective measures and follow up with affected patients.

Sixth, patient feedback should become a routine management resource rather than an occasional exercise. The hospital should introduce brief exit surveys, electronic feedback channels, follow-up calls and periodic patient-experience assessments. Data should be analysed by department to identify recurring patterns in staff conduct, delays, communication, billing, navigation and perceived quality.

Seventh, the hospital should strengthen personalised follow-up after care, particularly for patients with chronic conditions, surgical procedures, maternity care and complex treatment plans. Follow-up telephone calls, appointment reminders and post-discharge communication can demonstrate institutional concern while strengthening continuity, trust and the patient's relationship with the hospital.

Eighth, staff performance appraisal should include measurable patient-experience indicators alongside technical and clinical indicators. These could include communication quality, complaint frequency, response time, patient commendations, adherence to service standards and participation in customer-care improvement activities. Recognition mechanisms should also be developed for departments and staff who consistently demonstrate exemplary patient care.

Ninth, administrative processes should be simplified wherever possible. The qualitative findings indicate that patient dissatisfaction is not confined to clinical encounters; difficulties with registration, billing, movement between departments and access to information can also influence non-return. Process mapping should therefore be conducted to eliminate unnecessary steps and improve coordination between administrative and clinical functions.

Finally, the hospital should establish an integrated Patient Experience and Retention Dashboard bringing together customer-care indicators, service-quality measures, complaints, repeat attendance, referral patterns and patient satisfaction. Such a system would allow management to identify deterioration in patient experience before it translates into loss of clientele.

Future research should examine customer care longitudinally and investigate the mechanisms through which empathy, communication, trust, response time and service recovery influence actual repeat utilisation. Further

studies across PNFP hospitals would also help determine whether the relatively strong customer-care effect observed at Lubaga Hospital is consistent across different institutional and regional settings.

Overall, the evidence indicates that patient retention at Lubaga Hospital is not merely a function of what clinical service is provided, but also how the patient is treated throughout the service encounter. Customer care should therefore be positioned as a strategic management function that connects clinical quality, institutional reputation, trust and long-term patient relationships.

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