Loyalty Programmes and Client Retention in a Private Not-For-Profit Hospital: Evidence from Lubaga Hospital, Uganda

Nannyondo Grace[1]*, J.M.O. Tukei[2]

Lubaga Hospital, Uganda[1]

Police Health Services[2]

DOI: https://doi.org/10.47772/IJRISS.2026.101100167

Received: 15 October 2026; Accepted: 20 October 2026; Published: 21 November 2026

ABSTRACT

A hospital may reward repeat patients and still fail to create durable loyalty. In healthcare, a loyalty card cannot compensate for weak trust, fragmented continuity or an uncertain care experience. The strategic question is therefore not whether a loyalty programme exists, but whether patients experience it as clinically meaningful relationship value. This article analyses the association between loyalty programmes and client retention at Lubaga Hospital. Methodologically, the parent study used a cross-sectional mixed-methods design: 148 questionnaires were distributed, 107 usable questionnaires were returned, and 24 of 32 planned qualitative interviews were completed; descriptive statistics, Pearson correlation, multiple regression and qualitative content analysis were used. Loyalty programmes averaged 3.63, whereas retention averaged 4.03. The bivariate relationship was weak and non-significant ($r = .106$, $p = .279$), and the adjusted regression coefficient remained positive but non-significant ($B = .083$, $\beta = .124$, $p = .186$). Qualitative evidence nevertheless showed that personalised follow-up, coordinated care and relational continuity were valued. The article argues that loyalty programmes in PNFP hospitals should be designed as continuity-of-care architectures rather than promotional reward mechanisms, a conclusion that should be read alongside Article 2 on service quality and Article 3 on customer care.

Keywords: loyalty programmes; client retention; patient loyalty; relationship marketing; PNFP hospitals; Uganda

INTRODUCTION AND PROBLEM FRAMING

Client retention is a strategic concern for private not-for-profit hospitals because repeat utilisation stabilises revenue, reduces the cost of repeatedly acquiring new clients, supports continuity of care and can deepen relational trust. Yet healthcare loyalty is structurally different from retail loyalty: patients are simultaneously consumers, care recipients and risk-bearers, and their return decisions can be shaped by perceived competence, safety, empathy, affordability, access and prior outcomes. Consequently, loyalty programmes can contribute to retention only when they reinforce the underlying care relationship rather than attempting to substitute for it (Alshurideh et al., 2020; Fook & Dastane, 2021; Hofman-Kohlmeyer, 2016; Khairawati, 2020; Magatef & Tomalieh, 2015; Watson et al., 2015) (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 case is analytically important because the hospital had invested in customer-care skills, quality standards and loyalty-related initiatives while outpatient volumes remained volatile: 205,789 visits were reported in 2019, falling to 169,949 in 2020 and 166,058 in 2021, remaining almost flat at 166,352 in 2022 before recovering to 171,472 in 2023. These figures do not establish causation, but they create a practical management puzzle: formal retention strategies coexisted with a large post-2019 decline and only partial recovery. Relationship marketing literature similarly warns that loyalty programmes can produce weak incremental effects when perceived benefits are generic, programme awareness is low, switching decisions are dominated by core service quality, or trust and emotional commitment are not activated (Alshurideh et al., 2020;

Fook & Dastane, 2021; Hofman-Kohlmeyer, 2016; Khairawati, 2020; Magatef & Tomalieh, 2015; Watson et al., 2015) (Abekah-Nkrumah et al., 2021; Alam et al., 2021; Han & Hyun, 2015; Kwiatek et al., 2020; Payne & Frow, 2016; Vaniara & Pramono, 2022).

CONCEPTUAL AND THEORETICAL FOUNDATION

This article conceptualises loyalty programmes as structured initiatives intended to encourage repeat engagement, recognition, follow-up or relationship continuity. The key mechanism is not the reward itself but the additional perceived value and relationship signal created by the programme. Customer-relationship-management scholarship suggests that retention emerges when organisations use information, segmentation, communication and personalised interaction to improve relationship quality; loyalty-programme research similarly shows that programme architecture, relevance and perceived fairness determine whether behavioural repetition develops into attitudinal loyalty (Alshurideh et al., 2020; Fook & Dastane, 2021; Hofman-Kohlmeyer, 2016; Khairawati, 2020; Magatef & Tomalieh, 2015; Watson et al., 2015) (Abekah-Nkrumah et al., 2021; Alam et al., 2021; Han & Hyun, 2015; Kwiatek et al., 2020; Payne & Frow, 2016; Vaniara & Pramono, 2022).

The parent dissertation drew on Customer Service Theory, Social Penetration Theory and the Johari Window. These perspectives are complementary. Customer Service Theory frames retention as a consequence of reliable and responsive encounters; Social Penetration Theory explains how repeated communication and reciprocal disclosure can deepen relationships; the Johari Window highlights feedback, self-awareness and the reduction of blind spots in organisational interaction. In a hospital context, these ideas imply that a loyalty initiative is most defensible when it improves knowledge of the patient, continuity across encounters, responsiveness to feedback and relational confidence rather than merely distributing rewards (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).

Table 1. Analytical pathways linking loyalty programmes to client retention

Construct	Mechanism	Expected retention pathway	Cross-reference
Programme awareness	Patients understand benefits and access rules	Higher perceived value and programme use	
Personalisation	Follow-up, reminders, recognition and tailored communication	Stronger relational attachment and continuity	
Care integration	Programme linked to appointments, chronic-care pathways and service navigation	Lower friction in repeat utilisation	

METHODOLOGY

The article is derived from a cross-sectional mixed-methods study conducted at Lubaga Hospital in Kampala, Uganda. Quantitative and qualitative strands were used because a retention relationship can be estimated statistically while the meaning of loyalty, awareness and return intentions requires contextual explanation. A total of 148 questionnaires were distributed and 107 usable questionnaires were returned; 24 of 32 planned interviews were completed. Quantitative responses were measured predominantly on five-point Likert scales and analysed using descriptive statistics, Pearson correlation and multiple regression, while qualitative accounts were analysed thematically/content-wise. The cross-sectional design is appropriate for estimating associations but does not support temporal causal claims, and the interpretation therefore remains associational (Krejcie & Morgan, 1970; Roberts & Priest, 2006; Wang & Cheng, 2020; Amporfro et al., 2021; Akdere et al., 2020).

The analytical sequence intentionally separates three questions that are sometimes collapsed: whether respondents positively perceived loyalty-programme activities, whether loyalty programmes covaried with retention at the bivariate level, and whether they retained an independent association after service quality and customer care entered the multivariable model. Reliability and validity are interpreted as prerequisites to coefficient interpretation, and statistical conclusions follow the reported coefficient and p-value rather than contradictory narrative wording in the dissertation. This discipline is particularly important because a favourable mean score does not logically imply predictive significance, and a non-significant independent coefficient does not mean the programme has no managerial value (Krejcie & Morgan, 1970; Roberts & Priest, 2006; Wang & Cheng, 2020; Amporfro et al., 2021; Akdere et al., 2020) (Alshurideh et al., 2020; Fook & Dastane, 2021; Hofman-Kohlmeyer, 2016; Khairawati, 2020; Magatef & Tomalieh, 2015; Watson et al., 2015).

RESULTS

Table 2. Descriptive and bivariate results

Statistic	Loyalty programmes	Customer retention	Interpretation
Mean	3.63	4.03	Both above scale midpoint
Standard deviation	0.957	0.644	Greater dispersion in loyalty perceptions
Pearson r	.106	.106	Weak positive relationship
p-value	.279	.279	Not statistically significant at .05

Table 3. Multivariable coefficients predicting customer retention

Predictor	B	SE	β	T	p	Decision
Loyalty programmes	.083	.063	.124	1.332	.186	Positive; not independently significant
Service quality	.200	.106	.182	1.884	.062	Positive; borderline/non-significant at .05
Customer care	.231	.095	.237	2.439	.016	Positive; significant

Table 2 shows that the direction of association was positive but substantively small and statistically non-significant ($r = .106$, $p = .279$). Table 3 reinforces this finding after simultaneous adjustment: loyalty programmes retained a positive coefficient ($B = .083$; $\beta = .124$) but did not reach the conventional .05 significance threshold ($p = .186$). The correct inference is therefore not that loyalty programmes reduce retention or that they are useless; rather, the data do not demonstrate a robust independent statistical association in this sample. This distinction is consistent with research showing that loyalty effects often depend on satisfaction, relationship quality, trust, differentiation and benefit relevance (Alshurideh et al., 2020; Fook & Dastane, 2021; Hofman-Kohlmeyer, 2016; Khairawati, 2020; Magatef & Tomalieh, 2015; Watson et al., 2015) (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 Why positive programme perceptions did not translate into a strong retention coefficient

The first explanation is a programme-mechanism gap. Respondents may recognise that loyalty initiatives exist yet fail to experience them as decisive reasons for choosing the hospital again. In healthcare, return behaviour is often dominated by clinical trust, perceived quality, provider familiarity and emotional reassurance; a formal programme may therefore function as a supporting cue rather than a primary driver. This explains why a positive

descriptive assessment can coexist with a weak correlation and aligns with studies showing that rewards are most effective when embedded in a broader high-quality relationship (Alshurideh et al., 2020; Fook & Dastane, 2021; Hofman-Kohlmeyer, 2016; Khairawati, 2020; Magatef & Tomalieh, 2015; Watson et al., 2015) (Abekah-Nkrumah et al., 2021; Alam et al., 2021; Han & Hyun, 2015; Kwiatek et al., 2020; Payne & Frow, 2016; Vaniara & Pramono, 2022).

The second explanation is visibility and salience. Qualitative evidence indicated that some respondents were unaware of formal loyalty initiatives even while expressing willingness to return because of personalised care, coordination and confidence in clinicians. If programme awareness is uneven, the measured construct contains respondents who may be judging general hospital practices rather than a clearly identifiable loyalty architecture. Theoretical work on relationship marketing implies that a programme must communicate a distinctive value proposition, use relevant customer information and create recognisable benefits if it is to alter behavioural intention (Alshurideh et al., 2020; Fook & Dastane, 2021; Hofman-Kohlmeyer, 2016; Khairawati, 2020; Magatef & Tomalieh, 2015; Watson et al., 2015) (Abekah-Nkrumah et al., 2021; Alam et al., 2021; Han & Hyun, 2015; Kwiatek et al., 2020; Payne & Frow, 2016; Vaniara & Pramono, 2022).

5.2 Suppression by stronger experiential variables

The multivariable results suggest that customer care absorbed more explanatory power than loyalty programmes. As shown in Table 3, customer care remained statistically significant whereas loyalty did not; Article 3 develops this result and demonstrates how listening, responsiveness, professional conduct and communication appear directly in patients' accounts of return and non-return. Article 2 likewise shows that service quality was positively associated with retention at the bivariate level. Taken together, the three manuscripts support a layered interpretation: loyalty programmes may work downstream of, or through, service experience rather than as an autonomous retention engine (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).

MANAGERIAL AND POLICY IMPLICATIONS

For Lubaga Hospital and comparable PNFP facilities, programme redesign should move from generic rewards to continuity-of-care value. Practical options include appointment and medication reminders, post-discharge follow-up, chronic-care navigation, recognition of repeat patients, family-care coordination, transparent benefit rules and digital patient communication. Such interventions transform loyalty from a marketing device into a relationship-management system and are more consistent with health-service evidence linking satisfaction, trust, communication and perceived quality to continued utilisation (Abekah-Nkrumah et al., 2021; Alam et al., 2021; Han & Hyun, 2015; Kwiatek et al., 2020; Payne & Frow, 2016; Vaniara & Pramono, 2022) (Abekah-Nkrumah et al., 2021; Gudergan et al., 2008; Koca & Erigüç, 2020; Mangus et al., 2020; Spicuzza, 1992; Torres & Zhang, 2022).

Management should also evaluate loyalty initiatives with an explicit results chain: programme reach → awareness → use → perceived value → satisfaction/trust → repeat utilisation. Without this chain, high implementation activity can be mistaken for effectiveness. Routine dashboards should therefore distinguish enrolment from active use, segment outcomes by patient group, capture reasons for non-use, and compare retention among exposed and unexposed patients over time. This recommendation responds directly to the weak effect observed in Tables 2 and 3 and creates a more testable basis for future causal evaluation (Alshurideh et al., 2020; Fook & Dastane, 2021; Hofman-Kohlmeyer, 2016; Khairawati, 2020; Magatef & Tomalieh, 2015; Watson et al., 2015) (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 single-site cross-sectional design limits causal inference and generalisability, self-reported measures can be affected by common-method and social-desirability bias, and the dataset does not establish whether respondents

were formally enrolled in a uniform programme. Future research should use longitudinal patient-level data, explicit programme-exposure measures, segmented analysis, retention time horizons and mediation models testing satisfaction, trust and continuity as mechanisms. Multi-hospital PNFP studies would also clarify whether the Lubaga pattern is institution-specific or characteristic of the wider Ugandan private not-for-profit sector (Krejcie & Morgan, 1970; Roberts & Priest, 2006; Wang & Cheng, 2020; Amporfro et al., 2021; Akdere et al., 2020) (Abekah-Nkrumah et al., 2021; Alam et al., 2021; Han & Hyun, 2015; Kwiatek et al., 2020; Payne & Frow, 2016; Vaniara & Pramono, 2022).

CONCLUSION

The central finding is a disciplined negative result: loyalty programmes were positively perceived but were not a statistically robust independent predictor of client retention in the reported sample. That result is managerially valuable because it redirects attention from the existence of programmes to the mechanisms through which programmes create relationship value. Read together with Article 2 and Article 3, the evidence indicates that loyalty should be treated as an outcome of integrated quality, communication, continuity and trust, with formal programmes serving as an enabling platform rather than a substitute for excellent care (Alshurideh et al., 2020; Fook & Dastane, 2021; Hofman-Kohlmeyer, 2016; Khairawati, 2020; Magatef & Tomalieh, 2015; Watson et al., 2015) (Abekah-Nkrumah et al., 2021; Alam et al., 2021; Han & Hyun, 2015; Kwiatek et al., 2020; Payne & Frow, 2016; Vaniara & Pramono, 2022).

RECOMMENDATIONS ON CUSTOMER LOYALTY AND CLIENT RETENTION

1. Redesign loyalty programmes around continuity of care. Lubaga Hospital should emphasize personalized follow-up, coordinated care, continuity with healthcare providers, appointment reminders, post-treatment communication and long-term patient relationships rather than relying primarily on rewards or promotional incentives.
2. Strengthen patient engagement and personalized care. Patients should receive communication and services tailored to their individual health needs. Personalized interaction can strengthen trust, perceived value and willingness to return to the hospital.
3. Improve provider–patient communication. Health workers should receive continuous training in communication, empathy, responsiveness, courtesy and understanding patient concerns. Effective communication should become a measurable component of patient-care quality.
4. Institutionalize proactive follow-up mechanisms. The hospital should establish systematic mechanisms for following up discharged patients, chronic-care patients and clients requiring review. Digital reminders, telephone follow-ups and appropriate electronic patient-management systems can support this process.
5. Integrate loyalty initiatives with service quality. Loyalty programmes should not operate independently of clinical and service quality. Management should prioritize reliability of services, responsiveness, reduced waiting times, availability of required services, respectful treatment and efficient care coordination.
6. Establish continuous patient-experience monitoring. Regular patient-satisfaction surveys, exit interviews, suggestion mechanisms and real-time feedback systems should be used to identify factors influencing patients' decisions either to return or seek services elsewhere.
7. Strengthen complaint handling and service recovery. Complaints should be addressed promptly and transparently. A structured system should record complaints, assign responsibility, monitor response time and assess whether corrective actions have restored patient confidence.
8. Develop patient-centred customer-care standards. Lubaga Hospital should institutionalize standards covering reception, communication, response times, privacy, dignity, empathy, complaint resolution and follow-up. Compliance should be routinely monitored by management.

9. Segment patients for appropriate retention interventions. Different categories of patients such as chronic-care patients, maternity clients, surgical patients, outpatient clients and repeat users have different expectations. Loyalty strategies should therefore be tailored to their respective needs rather than applying one uniform programme.

10. Benchmark and continuously innovate customer-care practices. The hospital should periodically compare its patient-experience and retention practices with other reputable healthcare institutions and adopt suitable innovations in communication, patient navigation, digital engagement and care coordination.

11. Empower management and frontline staff. Departmental managers and frontline health workers should be given clear responsibility, appropriate authority and measurable targets for improving patient experience and retention.

12. Create a patient-retention performance dashboard. Management should regularly monitor indicators such as repeat visits, waiting time, complaints, patient satisfaction, follow-up completion, referral losses, appointment adherence and reasons for non-return.

REFERENCES

1. Abekah-Nkrumah, G., Antwi, M. Y., Braimah, S. M., & Ofori, C. G. (2021). Customer relationship management and patient satisfaction and loyalty in selected hospitals in Ghana. International Journal of Pharmaceutical and Healthcare Marketing, 15(2), 251–268.
2. Akdere, M., Top, M., & Tekingündüz, S. (2020). Examining patient perceptions of service quality in Turkish hospitals: The SERVPERF model. Total Quality Management & Business Excellence, 31(3–4), 342–352.
3. Alam, M. M. D., Karim, R. A., & Habiba, W. (2021). The relationship between CRM and customer loyalty: The moderating role of customer trust. International Journal of Bank Marketing, 39(7), 1248–1272.
4. Alshurideh, M., Gasaymeh, A., Ahmed, G., Alzoubi, H., & Kurdi, B. (2020). Loyalty program effectiveness: Theoretical reviews and practical proofs. Uncertain Supply Chain Management, 8(3), 599–612.
5. Amporfro, D. A., Boah, M., Yingqi, S., Wabo, T. M. C., Zhao, M., Nkondjock, V. R. N., & Wu, Q. (2021). Patients' satisfaction with healthcare delivery in Ghana. BMC Health Services Research, 21, 1–13.
6. Fook, A. C. W., & Dastane, O. (2021). Effectiveness of loyalty programs in customer retention: A multiple mediation analysis. Jindal Journal of Business Research, 10(1), 7–32.
7. Gudergan, S., Beatson, A., & Lings, I. (2008). Managing service staff as an organizational resource: Implications for customer service provision. Services Marketing Quarterly, 29(4), 25–41.
8. Han, H., & Hyun, S. S. (2015). Customer retention in the medical tourism industry: Impact of quality, satisfaction, trust, and price reasonableness. Tourism Management, 46, 20–29.
9. Hofman-Kohlmeyer, M. (2016). Customer loyalty program as a tool of customer retention: Literature review. CBU International Conference Proceedings, 4, 199–203.
10. Khairawati, S. (2020). Effect of customer loyalty program on customer satisfaction and its impact on customer loyalty. International Journal of Research in Business and Social Science, 9(1), 15–23.
11. Koca, G. Ş., & Erigüç, G. (2020). The effects of communication skills levels of health professionals on the dimensions of the Johari Window model. International Journal of Healthcare Management, 13(sup1), 434–446.
12. Krejcie, R. V., & Morgan, D. W. (1970). Determining sample size for research activities. Educational and Psychological Measurement, 30(3), 607–610.
13. Kwiatek, P., Morgan, Z., & Thanasi-Boçe, M. (2020). The role of relationship quality and loyalty programs in building customer loyalty. Journal of Business & Industrial Marketing, 35(11), 1645–1657.
14. Magatef, S. G., & Tomalieh, E. F. (2015). The impact of customer loyalty programs on customer retention. International Journal of Business and Social Science, 6(8), 78–93.
15. Mangus, S. M., Bock, D. E., Jones, E., & Folse, J. A. G. (2020). Examining the effects of mutual information sharing and relationship empathy: A social penetration theory perspective. Journal of Business Research, 109, 375–384.

16. Payne, A., & Frow, P. (2016). Customer relationship management: Strategy and implementation. In M. J. Baker & S. Hart (Eds.), The marketing book (pp. 439–466). Routledge.
17. Roberts, P., & Priest, H. (2006). Reliability and validity in research. Nursing Standard, 20(44), 41–46.
18. Spicuzza, F. J. (1992). A customer service approach to advising: Theory and application. NACADA Journal, 12(2), 49–58.
19. Torres, E. N., & Zhang, T. (2022). Customer service marketing: Managing the customer experience. Routledge.
20. Vaniara, F. V., & Pramono, R. (2022). The effect of perceived value, customer satisfaction and trust on customer loyalty at the DM Clinic in East Jakarta. International Journal of Economics, Business and Accounting Research, 6(3), 2514–2519.
21. Wang, X., & Cheng, Z. (2020). Cross-sectional studies: Strengths, weaknesses, and recommendations. Chest, 158(1), S65–S71.
22. Watson, G. F., Beck, J. T., Henderson, C. M., & Palmatier, R. W. (2015). Building, measuring, and profiting from customer loyalty. Journal of the Academy of Marketing Science, 43, 790–825.