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Stakeholder strategies for service: conceptualising user-focused service in nursing home care

Freek Lapré[a,1] and Gillian Wright[b]*

[a]*TIAS School for Business and Society, University of Tilburg, Postbus 90153, 5000 LE Tilburg, The Netherlands;* [b]*Business School, Manchester Metropolitan University, All Saints, Oxford Road, Manchester M15 6BH, UK*

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In the context of the demographic imperative of the worldwide ageing population, this paper proposes a framework to understand the dimensions for service quality in stakeholder perceptions of elderly nursing home care. Using extant theory on service quality and satisfaction, we explore, through semi-structured interviews, the expectations and experience of service from the perspectives of residents, family/friends and service managers. Our conceptualisation has resonance with generic notions of service quality: responsiveness, tangibles, assurance and empathy. However, systems orientation is an additional important element of experience. Expectations included issues concerning the room, care comparable to home and service outcome (returning home).

Keywords: service; quality dimensions; care

Introduction: the imperative of ageing

Worldwide, societies are ageing and this will lead to an increasing demand for many services, notably and importantly the need for long-term care. In 2000, 10% of the world population of 6 billion was over 60 years old. By 2050, this will have more than doubled to 22%. In real terms, with a projected population of 9 billion, there will be 1.89 billion people in this age group, an increase of 1.29 billion over 50 years (United Nations, 2010). In Western Europe, the proportion of people over the age of 60 will rise to 35% of the population by 2050 – from less than 22% in 2000, an increase of 64% or over 25 million people. In this paper, we take the Netherlands as an example of a Western European country which exemplifies this demographic challenge for service provision (Table 1).

Throughout Western Europe and many countries worldwide, mechanisms exist to publically fund medical and formal (institutional) elements of care and to varying extents to support personal and home-based (informal) care. The Netherlands, in which this research was undertaken, was an early adopter of responsibility for funding formal care with their 1967 Exceptional Medical Expenses Act. The Netherlands has a well-developed health and social care infrastructure for elderly care (Saltman, Dubois, & Chawl, 2006), and this health sector has high social impact and is a significant commitment of public funds. These features are forecast to increase in magnitude over the next four decades, thus highlighting the importance of this research in terms of community health and economic commitment.

*Corresponding author. Email: g.wright@mmu.ac.uk

Table 1. Ageing populations.

	Worldwide		Western Europe		The Netherlands	
	2000	2050	2000	2050	2000	2050
Population (000s)	6,115,367	9,149,984	183,001	184,908	15,915	17,399
Life expectancy	68.6	77.9	82	87.7	78.7	84.2
Over 60 (%)	9.9	21.9	21.7	35.2	18.2	31.3
Over 60 (000s)	603,538	2,008,244	39,622	65,048	2896	5445

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat (2009).

Future users of nursing home services will be increasingly demanding of the delivery of care services as the baby boom generation ages, and they will want an offer that is adjusted to their individual needs and lifestyle focusing not only on quality of technical care but also on quality of life (Roes, 2008). The nursing home industry thus faces a considerable challenge. To improve customer (resident) satisfaction, health care in general and the nursing home sector in particular are beginning to focus on the relationship between customer satisfaction and customer expectations – mainly through branding strategies. Health services have utilised some management approaches developed in the private sector to good effect (Wright, Chew, & Hines, 2012), and specifically, the nursing home sector has drawn on the commercial service sector as to develop concepts of service quality (Kennedie, 2005; van Leeuwen, 2006). There remains debate, however, about the applicability of service quality concepts to the health sector, and this paper is concerned with how the characteristics of nursing home care influence the conceptualisation of service quality.

The research aim was to identify the underlying themes in the conceptualisation of quality in nursing homes through a series of research questions:

- Can extant conceptualisation of service quality and satisfaction be transferred to nursing home care service?
- What do stakeholders (residents, families and managers) perceive as important in nursing home care?
- How do expectation and experience differ?
- What is the relationship of expectation and satisfaction?

Evaluating services

Service satisfaction is the 'post-consumption evaluation of the service quality' (Grönroos, 1984) results from the perceived quality of service relative to initial expectations of it (Douglas & Connor, 2003; Grönroos, 1984; Santos & Boots, 2003). In nursing homes, it is established as important that providers to define adequately the service offering to create realistic expectations (Bebko, 2000). The nursing home sector is especially interesting because, unlike other services, there is an element of permanency associated with it (Leventhal, 2008).

Expectations of service

Expectations have been posited as predicting satisfaction, forming the reference point from which services are judged. Studies of hospital care (Conway & Wilcocks, 1997;

Gilbert, 1992) and aged care (Leventhal, 2008) have suggested that expectations may be important in nursing home services. The notion of disconfirmation (Bolton & Drew, 1991; Churchill & Surprenant, 1982) is premised on high evaluations of service quality occurring when delivered service is better than expected. Conversely, when delivered service is worse than expected, the evaluation services is correspondingly low (Hamer, 2006). Disconfirmation is tacitly accepted in much contemporary research (Grönroos, 2007), though the role of expectations is demonstrably complex. Expectations can be predictive, normative or comparative (Prakash, 1984), and predictive expectations are most closely correlated with post-purchase evaluation (Prakash, 1984) and the most reliable predictor of perceived service quality (Hamer, 2006). However, the judgement of delivered service is not always based on clear disconfirmation (Cronin & Taylor, 1992; Kopalle & Lehmann, 2001), but rather on normative expectations and so the weighting of the importance of service attributes is central to a positive quality evaluation. Thus, experience is taken as a key influence on the judgement of quality (Boulding, Kalra, Staelin, & Zeithaml, 1993; Lee, Lee, & Yoo, 2000).

Modelling service quality

The generic disconfirmation model, SERVQUAL, is pre-eminent (Parasuraman, Zeithaml, & Berry, 1985, 1988) and comprises five dimensions: tangibles, reliability, responsiveness, assurance and empathy. The model suggests five ways in which perceived service quality can be misinterpreted or misdelivered (Parasuraman et al., 1985): consumer expectations and management perceptions; management perceptions and service quality specification; service quality specifications and service delivery; service delivery and external communications; and expectations of service and experienced service.

Service quality research in healthcare has drawn heavily on SERVQUAL which has been applied in hospitals (Babakus & Mangold, 1992) and long-term care facilities (Curry, Stark, & Summerhill, 1999; Kilbourne, Duffy, Duffy, & Giarchi, 2004) and has been suggested as a potentially reliable instrument to address service quality in nursing homes (Duffy, Duffy, & Kilbourn, 2001).

Satisfaction with services

Service expectations and service quality converge in the debates around satisfaction the difference between satisfaction and quality. It is argued, based on managers and users research, that service quality equates to satisfaction (Iacobucci & Ostrom, 1995). Introducing the expectation/experience (dis)confirmation (Parasuraman et al., 1985) suggests that users may become satisfied with low-quality service (Bitner, 1990; Brady & Cronin, 2001; Grönroos, 2001; Roest & Pieters, 1997; Spreng & Mackoy, 1996). This body of research suggests that fit-for-purpose leads to satisfaction, which is thus context dependent. This debate is encapsulated in the dichotomy of whether quality is perceived first and then satisfaction follows, or if satisfaction with a service comes first and then leads to a quality perception (Grönroos, 2007).

Understanding expectations, experience and satisfaction

The body of research in service quality thus highlights an agenda to explore the validity of disconfirmation, and specifically the notion and role of predictive, normative and comparative expectations and their impact on satisfaction. It also emphasises further

exploration of the relationship between satisfaction and quality. SERVQUAL is a useful model to structure service quality research as it incorporates dimensions and delivery, and it is intended for adaptation to context, although this contextualisation in the health care sectors remains limited. Though there has been some use expectations, experience and satisfaction, there is room to extend this to include the challenging issues of the nature of the customer (consumer plus other involved customer stakeholders) and the specific long-term nature of nursing home services. Thus, using the established generic elements of service quality and satisfaction, there is scope to explore the nursing home context to contribute to understanding effective service delivery in this sector.

Research method

The research questions concern the identification of underlying dimensions of service quality in nursing homes to develop a theoretical framework depicting these, and so this context lends itself to the use of semi-structured interviews. The sampling frame was drawn from Verzorgings, Verpleeg – Ziekenhuizen en Serviceflats in Nederland (VVZS, 2010), a national directory of nursing homes. Locations approached through an invitation letter and nursing homes provided access to residents and their families. After introductory letters to the family, follow-up telephone calls led to 100% agreement from the selected service users. The Executive Director of three nursing homes also participated in the study. Interviews were conducted privately and with informed consent regarding participation and tape-recording. The fieldwork comprised 22 face-to-face semi-structured in-depth interviews with 12 nursing home residents with physical limitations and 10 family members of residents with dementia. Residency ranged from 6 weeks to 6 years. Adopting a critical incident approach, respondents were encouraged to talk about how they chose a nursing home and their expectations and evaluations. Executive Directors discussed their opinions of their service and how they believed their clients viewed the service and what is important to them. Data coding was located between theory-driven and data-driven approaches, characteristic of thematic analysis where coding is partly based upon prior research (Boyatzis, 1998). The variables were grouped to develop a framework, grounded in expectations and experience that could be compared with extant frameworks. Thus, the analysis was undertaken in an inductive, data-driven way (Boyatzis, 1998; Braun & Clarke, 2006).

Results

Analysis identified 21 initial themes that we expected would group easily into the categories of expectations and experiences. It became clear, though, that in this context, the experiences were divided into two elements – pre- and post-decision – hence the decision-making process itself is a distinct element in the development of nursing home perceptions (Table 2). The words of respondents are in *italics*.

Expectations

Emergent themes focused on concerns about the responsiveness of care and outcomes. Responsiveness to individual needs was expressed as the hope that institutional *care comparable to home* would mirror previous comfort levels. Linked to this was the nature of the tangible personal living space and whether *promises about the room* were likely to be met. The difficulty of evaluating promises about the room and how this affects the

Table 2. Context specific expectations and experiences of nursing homes; thematic analysis.

	Experiences		
Expectations	Decision-making: choosing	Service experience (residency)	
Care comparable to home	Negative choice	Ability to make choices	Prompt service
Promises about the room	Not an instant decision	Adaptation	Confrontation with death
Going home	Others make the choice	Acceptance of situation	Feeling safe
	Location	Treated with respect	Dining
	Accommodation	Dignity	Privacy and personal space
		Social inclusion	Homely environment
			Communication

evaluation in this service are demonstrated in the experience of being promised a private room 'they showed us the most beautiful room', though consequently,

> he got his private room, but had to move five times, because it was the death room. The most beautiful room is still in the brochures, they should have to put the four person room into that brochure. I would rather put him into a jail.

The final theme in this category, *going home*, reveals the complex nature of the nursing home context. There was a thread of narrative, which hoped that nursing home residence was a temporary need the potential resident always initially expected to return home after rehabilitation.

Care comparable to home is and expectation about service delivery, and *promises about the room* form the basis of expectations of tangible accommodation. *Going home* is the expectation of the result of the service: 'I said – don't give dad away to others, after 30 admissions to hospital, the nursing home was the final reality – then you realize that he is not coming back'.

Experiences: decision-making

Decision-making period provided a connection between expectations and service experience. The *location* of the nursing home was important, since respondents and family wanted to feel that a normal relationship could be maintained easily. The *accommodation* is important: a private room was seen as crucial in their decision. Managers saw rooms as most important in differentiating them from competitors.

Central to decision-making was that it is *a negative choice*, based on a (usually progressively degenerating) home situation becoming untenable for the resident to care for themselves or be adequately provided for. Families accepting the need for nursing home care were troubled with feelings of failure and guilt. The decision to move to a nursing home was a progressive move, *not an instant decision*, and it emerged in all cases that it was a journey from hospital to a rehabilitation unit and finally to the nursing home. In all cases, residents felt that *others make the decision* for them: family or professionals. The *negative choice* was seen as embedded in a long decision-making process which in the main was enacted by others. The *location* and *accommodation* themes are associated with the physical attributes of a nursing home whilst the three other themes are concerned with making the decision.

Experiences: residency

Themes related to experience of residency are more diverse then those related to expectations and the decision-making process, though they can be summarised in three main categories as choice, dignity and safety. The management of a nursing home limits the *ability to make choices* about issues as diverse as personal accommodation, going out for a walk, having a pet, daily routines of waking and going to bed: 'you feel like a prisoner, I could do what I wanted to do in my own little house, but now it is like facing a dictatorship'. Residents and their families are confronted with a way of living to which they are unused whilst they are trying to adapt to the reality of having to live in a nursing home. Having accepted the need for residency, there was adaptation to the way the services are provided. This *acceptance of situation* concerns the feeling that the resident and their family experience a situation they do not want, but must to accept because there is no option. Consequently, *adaptation* expresses residents' experience of something negative but necessary, and thus the accommodation of the nursing home routines.

Likewise, residents felt little control over the timeliness of service delivery, *prompt service*, concern with waiting times was a recurring theme: 'if you need to go to the rest room you need to ask and then wait for half an hour; they just say "I'll be there in a moment" and then you wait half an hour, sometimes they forget'. Allied to these themes, *communication* of events such as changes to care plans was seen as sporadic and disempowering.

The nature of the environment was expressed in terms of a *homely atmosphere* rather than 'living in a facility'. This notion of homeliness was more dominant for residents who no longer had a spouse living in their old home. This theme is a good example of the relationship between experience and satisfaction – the current situation in a nursing home as a necessity may be acceptable and thus positive; however, satisfaction, using the previous home as a reference point, is negative. *Privacy and personal space* linked to the notion of a homely atmosphere. The *dining* experience was a specific, recurring issue, focusing on both the technical quality of the food and drink, and the dining experience. A choice of food was important as was the quality of social interaction. Some residents chose their menus 1–3 weeks in advance, which they disliked and forget what they ordered.

Dignity was raised in the context of the physical accommodation, and single-occupancy bedrooms were the clear preference though they often lacked this choice. Half of the residents had their own bedroom and some had their own furniture, although for most, there was no space for this. While interpersonal encounters were important, being treated with *respect* and courtesy by nursing home staff was a recurrent issue: 'they have no time for you … they have hardly time to take care of you'; respondents wanted to feel that they had retained their *dignity*: 'they put him at the table and leave him there – the same with all of them – and then they leave' even though their circumstances had changed 'you do not own so much anymore, have no significance to others and nothing to tell'. This was important as respondents felt reliant on others to maintain their dignity in their changed health and social circumstances. Taking part in community life reduced feelings of isolation and *social inclusion* was something that should be encouraged by nursing home staff: 'he has to have someone next to him who is able to talk, but mostly no one talks, no-one says anything, then he falls asleep'.

Safety was a fundamental drive to seek nursing home services and *feeling safe* was important mostly to families who wanted assurance of protection. There was realisation and acceptance that a nursing home is a last resort, and *confrontation with death* was undesirable and too often experienced through the death of a room-mate or other resident:

'we were having coffee in the restaurant and there was a dead person taken past on a stretcher'.

Managing a nursing home

Despite attempts to focus discussion on resident choice and experience, managers consistently diverted to the business model of nursing homes. They were preoccupied with budget restraints, staff shortage, job rotation, benchmarking, attraction as an employer and quality assurance. Attempts to direct discussion to the user perspective unfailingly returned to these concerns: 'people increasingly think that everything is still possible, they have to be re-educated about this; expectations clash tremendously with the finances and the availability of the staff'. Managers saw quality as something to be rationed in the context of limitations and constraints, rather than something to be understood in a responsive frame of mind.

Conceptualising nursing home care

The detailed thematic analysis was summarised as a conceptual framework through a final coding exercise to produce dimensions that were clearly named, defined, had discrete content, possible to evidence and had (Boyatzis, 1998). The original themes were considered individually and jointly leading to the 22 initial ideas being conflated to 12 themes (Table 3), covering expectations, the decision-making process and experiences in the nursing home.

Being cared for like home is the 'software' of a nursing home: the *care delivery* process. *Tangibles* are promises made in publicity and there is a specific notion of an *outcome* of the service – that it will not be permanent. In decision-making, the nature of the *choice* highlighted that nursing home care is not a welcomed service, rather a negative choice and at

Table 3. Understanding expectations and experiences of nursing homes: a conceptual framework.

Expectations (hopes and fears)	Decision-making (choosing)	Experiences (residency)	
Care delivery	*Choice*	*System orientation*	Ability to make choices
Care comparable to home	Negative choice		Acceptance of situation
	Not an instant decision		Adaptation
Tangibles	Others make the choice		
Promises about the room		*Tangibles*	*Empathy*
	Tangibles	Homely atmosphere	Treated with respect
Outcome/result	Location	Privacy and personal space	Social inclusion
Going home	Accommodation	Dining	Dignity
		Responsiveness	*Assurance*
		Prompt service	Feeling safe
		Communication	Confrontation with death

this point *tangibles* are concerned with location, ease of family access and features of the accommodation. The issues concerning choice during residency were relabelled as *system orientation*. This label captures the underlying driver that influences the range of options available to residents. System orientation concerns the way services are organised, and it is a dominating influence on the flexibility and thus the everyday lives of residents.

Tangibles are expressed as the outcomes of the physical environment: a homely environment, privacy/personal space and dining. *Responsiveness* concerns the delivery of care, the willingness to help residents by providing prompt service and effective communication. Being treated with respect, social inclusion and dignity combine as *empathy* which is concerned with individualised attention and care. *Assurance* captures the elements of feeling safe and confrontation with death, it is also concerned with the knowledge and courtesy of staff along with their ability to inspire trust and confidence.

Discussion

The first research question concerned the transferability of extant conceptualisation of service quality to nursing care. Many element of existing conceptualisation hold good: notably tangibles, responsiveness, empathy and assurance. However, three outcomes form a distinct difference. First, the emergence of themes specific to this context: outcome/result at the expectation stage; the nature of the decision and the decision-making stage; and system orientation during the experience of service. Second is the clear identification of the decision-making period as a distinct element that needs to be included in conceptualisation.

Third, reliability was not confirmed as an important theme, possibly because trust in medical care is vested in other professionals and is separate.

These issues reflect technical expectations (as a result of the interaction) and the functional level (how the result is achieved) (Grönroos, 2007). The first phase of the process was characterised more by hopes and fears than by what could be labelled expectations, and the (negative) emotional nature of the decision implies a specific perception of this stage.

The second research question addresses perceptions of the important elements of care. It emerged that care is initially seen as temporary and when this is unfeasible, there is hope that care will equate to living at home and that they will have their own room.

In an unpleasant situation that cannot be changed, residents adapt to system dominance.

Though residents held firm views, families were more consumerist. Residents felt vulnerable: ‘you don’t want to complain too much, you know you need these people’, whilst there were underlying feelings of guilt on the part of families: ‘it took a long time to come to terms with not being able to cope at home, I felt I was abandoning him’. The high involvement of families in decision-making highlights the need for differently targeted messages.

Managers were aware of, and focused tangibles in attracting new residents. Cost management is focused on buildings and staff, and operational protocols were important to managers. It is these that have led to the importance of system dominance, an important finding of this study.

Managers know that residency is likely to be for life and so have no appreciation of the hope of a temporary stay. Though managers understand the importance of homely care, they dismiss this as unrealistic without understanding what people see this as. Thus, there is clearly a service gap between suppliers and users (Parasuraman et al., 1988).

In the decision-making stage, managers place more emphasis on tangibles than do residents, and the importance of this stage is generally underestimated by managers.

Residents want to experience empathy, flexibility and tangibles whilst managers emphasise system constraints and tend not to focus on client-orientation.

Decision-making is long and traumatic (Butcher, Holkup, Park, & Maas, 2001), based on a negative choice, and the decision *is* made by those others than the resident, and thus the customer roles of information seeker, decision-maker and consumer are separated.

The third research question concerned the difference between expectations and experience. The notion of outcome/result was only present in the initial, pre-decision stage of the process, suggesting that it is part of coming to terms with the situation and seeing the service as 'life sentence' in the words of respondents. During residence, interpersonal issues – responsiveness, empathy and assurance – were especially important, reflecting emphasis on the day-to-day quality of life of residents. There was an expectation/experience gap concerning tangibles. During pre-decision, promises were all there was to go on, during decision-making this was consolidated to location and the room specification and finally during experience the specific manifestations of tangibles were a homely atmosphere, privacy/personal space and dining. The initial promises were generally considered unmet.

Finally, this paper considers the relationship between expectations and satisfaction. On this point, we conclude that the benchmark for satisfaction is not prior service expectations but rather the nature of lifestyle during residency compared to the previous home situation. Expectations are not developed beforehand, but evolve in the stage that the need for care becomes clear. Often, the potential resident is unaware or uninvolved in elements of the decision-making process, and his/her expectations develop during residency. These expectations are referenced to system dominance and this narrows the expectation/experience gap, reducing the usefulness of the notion of disconfirmation. Thus, the use of disconfirmation is complex and should be approached carefully as expectations shift as the result of adaptation to an unwelcome, traumatic situation. Thus, adaptation to the experienced reality of care is pertinent to the disconfirmation concept and so this research is in keeping with earlier work that indicates that satisfaction may be expressed even though disconfirmation occurs (Conway & Wilcocks, 1997; Gilbert, 1992) and that expectations may be downwardly adjusted to accommodate reality (Clark & Clark, 2007).

Note

1. Email: f.lapre@tias.edu

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