Journal of International Trade, Logistics and Law, Vol. 12, Num. 1, 2026, 37-62

PATIENT EXPERIENCE–BEHAVIORAL LOYALTY RELATIONSHIP: THE MEDIATING ROLE OF THE SERVICE MARKETING MIX

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Received: Oct 27, 2025 Accepted: May 30, 2026 Published: June 01, 2026

Abstract:
The aim of this study is to examine the relationship between patient experience and behavioral loyalty, and to evaluate the mediating role of the service marketing mix (7P) in this relationship. Data were obtained through a survey conducted with 460 participants who received services from public and private hospitals across Türkiye. The study utilized the Experience Quality (EXQ), Service Marketing Mix, and Behavioral Loyalty scales. Data were analyzed using Structural Equation Modeling (SEM) and bootstrap-based mediation analyses.
Findings indicate that experience quality has a direct and significant effect on behavioral loyalty, and that this effect is also indirectly transmitted through the marketing mix. Mediation analysis results revealed that process management, physical evidence, and people dimensions play a significant mediating role in the experience–loyalty relationship, with the highest mediation rate observed in the process dimension. Furthermore, the mediating relationships of each sub-dimension of the marketing mix were analyzed first collectively and then separately. These analyses showed that the promotion (communication) dimension alone was insufficient to increase behavioral loyalty, whereas its distinctive contribution became apparent when other marketing components were included in the model. The results demonstrate that marketing mix elements based on patient experience and structured with a holistic approach have a decisive effect on behavioral loyalty.

Keywords:
Healthcare Services, Patient Experience, Experience Quality (EXQ), Behavioral Loyalty, Service Marketing Mix

This study is derived from the doctoral dissertation titled "The Mediating Role of the Marketing Mix in the Relationship Between Patient Experience and Behavioral Loyalty in Healthcare Services," conducted under the supervision of Prof. Dr. Figen Yıldırım at the Graduate School of Social Sciences, İstanbul Ticaret University, Department of Marketing Management.

1. Introduction
Healthcare services have become increasingly complex due to technological advancements and growing competitive conditions, and patient-centered approaches have gained strategic importance (Gerteis et al., 1993; Berry, 1999; Jayadevappa & Chhatre, 2011). Today, healthcare organizations are moving beyond focusing solely on medical outcomes and are adopting patient-centered approaches that place patients' experiences at the core and enable their active participation in care processes. In this context, Berkowitz and Flexner (1981) revealed the existence of a non-traditional consumer segment in healthcare services—patients who play a more active role in the decision-making process compared to traditional patients. Patients are no longer seen as passive recipients of care; rather, they are actively involved in the design and evaluation of services, contributing to the improvement of the quality, accessibility, and effectiveness of care (Greene, Tuzzio & Cherkin, 2012).
Patient-centered communication, which plays a critical role in shaping the patient experience, stands out as an approach that focuses on understanding patients' experiences and ensuring their active participation in care

processes, thereby strengthening the quality of care (Newell & Jordan, 2015). This approach enhances patient satisfaction and the sense of trust while also providing a fundamental basis for long-term behavioral loyalty.

Patient experience refers to the entirety of interactions, emotions, perceptions, and behaviors that patients undergo throughout the service process and plays a decisive role in the formation of behavioral loyalty (Meyer & Schwager, 2007; Wolf, 2017). However, due to the characteristics of services such as intangibility, heterogeneity, inseparability, and perishability, the elements of the traditional marketing mix (4Ps: product, price, place, promotion) are insufficient when applied to service-oriented organizations (Zeithaml, Bitner & Gremler, 2017).

Therefore, the extended marketing mix—also known as the service marketing mix (7Ps) approach—(product/service, price, place, promotion, people, physical evidence, and process) provides a strategic framework in healthcare services (Öztürk, 2019; Wirtz, 2023). In particular, the dimensions of people, process management, and physical evidence are critical components in building an experience-oriented structure in healthcare services (Bitner, 1992; Ladhari, 2009; Chahal & Mehta, 2013).

A review of the existing literature reveals numerous studies examining the effects of service experience on satisfaction, loyalty, and word-of-mouth intentions (Klaus & Maklan, 2012; Kashif et al., 2016; Brandão & Ribeiro, 2023; Renaldo & Antonio, 2024; Abidin, Yudistria & Ramli, 2025); the effect of service quality on satisfaction and loyalty (Taylor & Baker, 1994; Chahal & Mehta, 2013; Addo et al., 2020); the effects of the 7P marketing mix on satisfaction and loyalty (Wooldridge & Camp, 2018; Chana et al., 2021; Huda & Yuliati, 2022; Astuti, Ichsan & Isa, 2025); and the impact of the 7P marketing mix on patients' hospital selection decisions (Ravangard, Khodadad & Bastani, 2020; Rahmawati & Susilowati, 2023). However, there is a limited number of studies that holistically examine the mediating role of the service marketing mix in the relationship between patient experience and behavioral loyalty.

In this context, the main objective of the present study is to examine the relationship between patient experience and behavioral loyalty and to evaluate the mediating role of the healthcare service marketing mix (7Ps) in this relationship. Within the scope of the study, it is aimed to provide significant findings for healthcare managers and researchers to develop patient-centered marketing strategies by analyzing how the service marketing mix serves as a bridge between patient experience and behavioral loyalty.

2. Theoretical Framework

In this section, the key concepts on which the research focuses—patient experience, behavioral loyalty, and the service marketing mix (7Ps)—are discussed in detail. The meanings of these concepts, the dimensions they consist of, and how they relate to each other will be explained with reference to the literature. In addition, this section presents the theoretical foundation of the research and provides a general perspective on the possible interactions among the variables.

2.1. Patient Experience

Patient experience is a strategic concept that refers to the entirety of patients' perceptions, emotions, and interactions at all touchpoints during the delivery of healthcare services. The framework defined by Donabedian (1980), one of the pioneers in the field of quality assessment in healthcare services, addresses healthcare quality under three dimensions: structure, process, and outcome. The structure dimension refers to the physical and organizational conditions in which the service is provided; the process dimension refers to the way the service is delivered; and the outcome dimension expresses the change in the patient's health status and the ultimate result of the service. In this context, factors such as communication quality, waiting times, physical environment, attitudes of healthcare professionals, and clinical processes directly shape the experience (Wolf et al., 2014).

Patient experience encompasses not only the fulfillment of expectations but also their exceeding, representing personalized care and patient-centered practices (Meyer & Schwager, 2007; Wolf et al., 2014). Patient-centered care goes beyond focusing solely on clinical outcomes and requires integrating patients' values, preferences, and experiences into care processes. Patients are no longer seen as passive recipients of services but are actively involved in the design and evaluation of services, contributing to the improvement of care quality, accessibility, and effectiveness (Greene et al., 2012).

Processes designed to be responsive to patients' needs create positive experiences regardless of clinical outcomes, and these experiences integrate with the principles of patient-centered care. Moreover, in the literature, the condition

known as customer delight, which arises when expectations are exceeded, is a critical factor that strengthens patient experience (Oliver, Rust & Varki, 1997; Torres & Kline, 2013). However, studies show that most organizations use the Customer Satisfaction Score (CSAT) or its derivatives such as Net Promoter Score (NPS) and Customer Effort Score (CES) to evaluate customer experiences (Dixon, Freeman & Toman, 2010; Klaus & Maklan, 2013).

Reducing patient experience merely to patient satisfaction is insufficient, because satisfaction is mostly measured through surveys and focuses on whether expectations are met (Bleich, Özaltin & Murray, 2009; LaVela & Gallan, 2014), whereas experience covers a much broader and deeper process (Meyer & Schwager, 2007; Wolf et al., 2014). In the literature, the Experience Quality (EXQ) scale, which emphasizes this conceptual distinction, goes beyond provider-oriented measurements of service quality and aims to evaluate all functional and emotional cues experienced by patients throughout the service process (Klaus & Maklan, 2012). The use of the EXQ scale conceptualizes patient experience from a holistic perspective and demonstrates that it explains behavioral loyalty and patient recommendations better than satisfaction (Klaus & Maklan, 2013; Kashif et al., 2016). In this context, patient experience is a process strengthened not only by positive clinical outcomes but also by exceeding expectations and taking into account patients' individual needs.

In this study, patient experience is conceptualized based on the Experience Quality (EXQ) model. Although the EXQ structure is less commonly used in the field of healthcare services compared to traditional scales such as SERVQUAL (Kashif et al., 2016), it provides an opportunity to evaluate experience more holistically (Klaus & Maklan, 2012). The scale consists of four sub-dimensions that assess patients' experiences on both emotional and functional levels: peace of mind, moments of truth, outcome focus, and product experience. These dimensions offer critical insights for understanding patients' perceptions and behavioral tendencies regarding healthcare services.

The traditional SERVQUAL model evaluates service quality in five dimensions (tangibles, reliability, responsiveness, assurance, and empathy) by assessing whether customer expectations are met (Parasuraman, Zeithaml & Berry, 1988), while the SERVQUAL Plus approach extends this model by addressing customer experience as a phenomenon larger than the mere cognitive assessments of service quality—one that is emotionally rich and felt over a longer duration (Buttle & Maklan, 2015, p. 194). Within this framework, the EXQ model provides a more comprehensive measurement of customer experiences by including elements such as emotional resonance and the creation of memorable experiences (Klaus & Maklan, 2013). Thus, in line with the experience economy approach (Pine & Gilmore, 1999), which argues that value stems not only from the product or service itself but also from the experience lived, businesses can strengthen their potential to create sustainable competitive advantage.

The EXQ model encompasses not only the tangible aspects of the service but also patients' feelings of emotional security, their interactions at critical touchpoints, and their perceptions of the outcomes obtained from the service. This multidimensional structure provides a significant advantage, especially for analyzing the effects of patient experience on behavioral loyalty. For instance, a positive experience increases patients' trust and commitment toward the healthcare institution, while negative experiences may weaken loyalty. In this context, patient experience management is handled holistically through touchpoints, moments of truth, and patient engagement elements (Buttle & Maklan, 2015). Touchpoints refer to every point where patients interact with the institution face-to-face, by phone, or through digital channels, while moments of truth represent the critical moments in which positive or negative judgments are formed during these interactions. In this regard, cognitive dissonance—in other words, the discrepancy between expectations and the actual experience—is also a determinant of satisfaction (Oliver, 1980; Sixma et al., 1998; Szymanski & Henard, 2001).

Research has shown that positive patient experience directly increases patient satisfaction (Doyle, Lennox & Bell, 2013). However, since satisfaction is often shaped according to expectations, it alone does not provide definitive information about service quality or patient loyalty. Patient experience, on the other hand, is a broader construct that forms the basis of satisfaction and helps explain its underlying reasons (Meyer & Schwager, 2007; Bleich et al., 2009). Therefore, focusing not only on satisfaction but on managing the entire experience ensures more lasting improvements in patient loyalty, service quality, and clinical outcomes.

In this context, patient engagement refers to patients' active involvement in their relationship with the healthcare institution and their development of commitment. Enhancing patient experience at all touchpoints supports patients' active participation in the healthcare process, contributing not only to reduced unnecessary hospitalizations but also to increased efficiency, effectiveness, service quality, quality of life, and responsiveness (Marzban et al., 2022). Thus, both patient behaviors and health outcomes can be positively affected. However, patient engagement can also be a

determinant of costs and other dimensions of service (Forbat et al., 2009). Patients who actively participate in the process have the potential to improve health outcomes and contribute to the transformation of services (Marzban et al., 2022).

Managing and improving patient experience not only creates satisfaction at the individual level but also represents a strategic value for the long-term success of healthcare institutions (Meyer & Schwager, 2007; Wolf et al., 2014). Therefore, many healthcare institutions today carry out systematic efforts to understand patient expectations, develop a service approach that values them, and strengthen the experience at every touchpoint. Digital health solutions, artificial intelligence–based technologies, and a strong organizational culture that enhance patient experience play a critical role in patient experience management. Berry's (1999) study includes strategic implications not only for the service sector but also for all customer-oriented organizations. For example, organizations that build trust-based relationships between employees and customers, prioritize social benefit, and emphasize values have been found to be more successful in creating brand loyalty and differentiating customer experience (Lemon & Verhoef, 2016; Hinds & Gupta, 2023). In this context, one of the main factors that strengthen patient experience is an organizational structure in which employees internalize the institutional culture and their relationship with patients is based on trust (Wolf, 2017; Wirtz, 2023).

2.2. Behavioral Loyalty

The concept of behavioral loyalty was first defined in the marketing literature in the 1970s within the framework of customers' repeat purchase behaviors (Jacoby & Chestnut, 1978). Oliver (1999) defined loyalty as the consistent preference of customers over time for a particular product or service provider, nourished by both cognitive and emotional commitment. In the context of healthcare services, behavioral loyalty refers to patients' tendency to choose the same healthcare institution again, to recommend it to others, and to continue receiving services from the same provider in the long term (Chahal & Mehta, 2013; George & Sahadevan, 2024).

Dick and Basu (1994) defined customer loyalty as the strength of the relationship between individuals' relative attitudes and their repeated behaviors and stated that this relationship is influenced by social norms and situational factors. This approach demonstrates that loyalty is a multidimensional structure supported by cognitive, emotional, and volitional elements. From the perspective of healthcare services, patient loyalty is not limited to repeat visit behaviors; it is also shaped by perceptual and motivational factors. In this context, experiential elements such as quality care, short waiting times, empathetic communication, a comfortable environment, and prompt feedback increase patient satisfaction and emotional commitment, thereby strengthening the tendency to repurchase and recommend (Hausman, 2004; Alrubaiee & Alkaa'ida, 2011; Ariffin et al., 2022; Brandão & Ribeiro, 2023).

At the same time, personalized communication and continuous interaction with the patient reinforce commitment (Brandão & Ribeiro, 2023). Therefore, the personal and emotional bond that the patient establishes with the institution strengthens loyalty behaviors (Ladhari, Souiden & Dufour, 2017). In addition, elements such as physical care, clinical competence, communication, and process management have a direct impact on loyalty (Chahal & Mehta, 2013). Furthermore, patients' perceptions regarding the benefit–cost balance of the service they receive affect their decision to choose the same institution again (Zeithaml, 1988).

Oliver (1980) emphasized that satisfaction is the fundamental determinant of behavioral intention, while Taylor and Baker (1994) revealed in their study that service quality and customer satisfaction are the main determinants in the formation of consumers' purchase intentions. George and Sahadevan (2024), in order to analyze the factors determining the behavioral intentions of inpatients, adopted as a theoretical lens the model proposed by Oliver (1980), which demonstrates the behavioral dimensions of satisfaction related to consumers, and developed a four-stage model that includes cognitive evaluation, emotional attachment, intention to revisit, and intention to recommend. According to their model, quality in healthcare services is shaped through cognitive–functional elements, patient satisfaction is determined by emotional experiences, trust and commitment are explained by volitional elements, and behavioral intention emerges at the action stage.

Zeithaml, Berry, and Parasuraman (1996) emphasized in their study that behavioral loyalty represents indicators of whether customers stay with or leave an organization. The scale they developed as a behavioral intentions scale addresses different aspects of customer behavior in five dimensions: loyalty, switching, willingness to pay more, external response, and internal response.

In this research, the behavioral loyalty scale used in the study by Kashif et al. (2016), which examined the relationship between experience quality, behavioral loyalty, and word of mouth in healthcare services, was utilized. The scale

measures patients' behavioral loyalty toward the hospital in terms of sharing positive things about the hospital with others, always recommending the hospital to anyone seeking advice, encouraging others to benefit from the hospital's services, and viewing the hospital as their first choice.

To strengthen behavioral loyalty, healthcare institutions must structure their organizational efforts in a way that enhances the trust and commitment between the patient and the service provider. In this context, it is important to continuously improve staff and technical standards, demonstrate approaches that are sensitive to individual patient needs, and strengthen physical infrastructure. This holistic approach supports the long-term sustainability of patient loyalty by improving patient experience at every touchpoint (Kashif et al., 2016; George & Sahadevan, 2024).

Berry's (1999) findings show that establishing customer and employee relationships based on mutual trust and transparency in service organizations is a determinant of loyalty. The creation of a culture of trust enables employees to take initiative without fear of making mistakes, to better meet customer expectations, and to develop emotional commitment to the organization (Ladhari, 2009).

2.3. The Relationship Between Patient Experience and Behavioral Loyalty

Patient experience is currently regarded as one of the most important indicators of quality of care and plays a decisive role in patient satisfaction, trust, and loyalty (Meyer & Schwager, 2007; Alrubaiee & Alkaa'ida, 2011; LaVela & Gallan, 2014). The literature emphasizes that positive patient experiences increase behavioral loyalty, strengthening the likelihood that patients will choose the same institution again, recommend the service, and develop long-term commitment (Meyer & Schwager, 2007; Torres & Kline, 2013).

In the healthcare sector, patient experience stands out as a critical factor that directly affects patients' perception of value and their perception of the quality of the provided healthcare services (Meyer & Schwager, 2007). When patients have positive emotional impressions during the healthcare process, this results in behavioral loyalty toward the institution; patients tend to choose the same healthcare organization again, recommend it to their acquaintances, and contribute to attracting new patients through positive word of mouth (Zeithaml et al., 2017; Torres & Kline, 2013). However, negative experiences not only cause existing patients to avoid returning to the institution but can also lead to the loss of a wider patient base due to negative comments that spread rapidly through social media and digital platforms (Klaus & Maklan, 2013). Today, the widespread use of information technologies and social media has made this effect more pronounced (Tosyalı, 2016). Therefore, continuously improving patient experience, exceeding expectations, and adopting a culture based on customer–employee interaction have strategic importance not only for being reselected by existing patients but also for ensuring the long-term sustainability of the institution by being preferred by other individuals who need healthcare services (Oliver et al., 1997; Kumar & Pansari, 2016).

Oliver et al. (1997) emphasized that satisfaction arises from meeting expectations, while "customer delight" results from exceeding expectations, and that experiences at the delight level have a stronger effect on loyalty. Alrubaiee and Alkaa'ida (2011), in their study examining the relationship among patients' perceptions of healthcare quality, patient satisfaction, and trust, and the mediating effect of patient satisfaction, revealed that establishing trust in healthcare services is possible not only through the provision of quality service but also by increasing patient satisfaction.

Klaus and Maklan (2012), with the four-dimensional EXQ (Experience Quality) scale they developed to measure customer experience, went beyond traditional satisfaction and service quality measurements and emphasized the long-term effects of experience on customers. Kashif et al. (2016) adapted this scale to healthcare services, examining its relationship with patient loyalty, satisfaction, and repurchase behavior from a broader perspective, and stated that positive patient experiences strengthen satisfaction and behavioral loyalty.

Chahal and Mehta (2013) found that service quality directly affects patient loyalty; Ladhari et al. (2017) determined that emotional satisfaction has a strong impact on perceived quality and behavioral intentions; Addo et al. (2020) showed that service quality strengthens patient satisfaction and loyalty; Brandão and Ribeiro (2023) revealed that trust, communication, and personalized service are the factors that most affect patient loyalty; Renaldo and Antonio (2024) stated that reliability plays a mediating role in the relationship between patient experience and loyalty; and George and Sahadevan (2024) developed a four-stage model in healthcare services that includes cognitive evaluations (perception of service quality), emotional bonds (trust and commitment), intention to revisit and recommend, and behavioral loyalty, explaining the direct and indirect effects of patient experience on loyalty behaviors. In addition, Chen et al. (2022) identified the direct effect of nursing experience on loyalty ($\beta = 0.298$) and its indirect effect

through overall service satisfaction (β = 0.162). These findings show that satisfaction-based approaches alone are insufficient and that patient experience is a strategic determinant for sustainable loyalty.

Loyalty in healthcare services refers not only to repeat visits but also to long-term relationships and competitive advantage. Reichheld (2003) stated that positive experiences provide financial returns and cost advantages, while Dixon et al. (2010) emphasized that loyalty is based not on exaggerated services but on the reliable fulfillment of core promises. Meyer and Schwager (2007) stated that systematically monitoring customer experience and effectively managing touchpoints offer strategic opportunities to build loyalty, while Moffett, Folse, and Palmatier (2021) emphasized that businesses increasingly recognize the value of meaningful and experiential interactions and allocate a significant portion of their marketing budgets to these areas. In this context, empathy-based and personalized experiences in healthcare services are also supported by the literature as factors that strengthen patient loyalty.

2.4. Service Marketing Mix (7P)

At the center of all processes in the delivery of products and services lies value creation. The fundamental distinction between products and services is the degree of tangibility or the extent to which they can be examined, touched, or experienced before purchase (Berkowitz, 2022). Therefore, a set of specific characteristics that define services has been identified. The features that distinguish value-creating services from physical goods are intangibility, inconsistency, inseparability, perishability, and interaction (Booms & Bitner, 1981; Zeithaml et al., 2017; Berkowitz, 2022). Hence, to address issues arising from the unique nature of services, three additional elements—process, physical evidence, and people—were added to the traditional 4Ps of product marketing (product, price, place, promotion), and thus the service marketing mix was conceptualized as 7Ps (Booms & Bitner, 1981; Wirtz, 2023).

Each of the business staff, patients, and other patients in the service environment provides cues about the nature of the service. Employees' attire, personal appearance, attitudes, and behaviors all shape patients' perceptions of the service (Zeithaml et al., 2017; Berkowitz, 2022). Especially in healthcare services, the communication skills and attitudes of personnel who are in direct contact with patients are critically important in determining patient experience, satisfaction, and level of trust (Wolf et al., 2014; Meyer & Schwager, 2007). Physical evidence encompasses the environment in which the service is provided and the tangible components of the service. Brochures, business cards, report formats, signage, equipment, and the facilities where the service is delivered are tangible representations of the service. Customers rely on these elements when evaluating the quality of intangible services (Öztürk, 2019). The process component includes the systems, procedures, mechanisms, and activity flows used in service delivery. It determines how the service is delivered and, in many cases, is considered by customers to be as important as the outcome of the service itself (Zeithaml et al., 2017).

In healthcare services, the environment in which the service is delivered, the qualifications of the personnel providing the service, and the way the service is delivered directly affect patients' perceived experience quality, satisfaction level, and sense of trust (Meyer & Schwager, 2007; Wolf et al., 2014). In particular, the effective management of processes, the design of the physical environment to support patients' sense of safety and comfort, and the competence of staff who interact directly with patients are fundamental components that improve patient experience and strengthen behavioral loyalty (Alrubaiee & Alkaa'ida, 2011; Mardaleta et al., 2022).

Healthcare services are a global service field with a complex and high-cost structure that directly affects economies and individuals' quality of life. The disciplines of service management, operations, and marketing play a critical role in providing solutions to the multidimensional problems in this sector (Berry & Bendapudi, 2007). In this context, the service marketing mix holds strategic importance not only for the development of marketing strategies but also for the holistic design of patient experience and the achievement of sustainable loyalty.

Services are performances that deliver desired outcomes or experiences for customers. In this sense, what customers value and are willing to pay for in exchange for money, time, and effort are the experiences and solutions they will have (Wirtz, 2023). Value defines the framework for improving performance in healthcare services (Porter, 2010). Therefore, the balanced creation and management of a patient-centered service marketing mix are critical to the success of healthcare organizations (Kotler, Shalowitz & Stevens, 2008). Service marketing mix strategies create a sustainable competitive advantage by increasing perceived value in patient experience and satisfaction (Berry & Bendapudi, 2007; Wooldridge & Camp, 2018).

Since services involve processes, an important issue in marketing a service is the quality of interaction between customers and service providers. This interaction should be evaluated from a co-creation of value perspective. It is important to emphasize that this interaction underscores the fact that healthcare services are co-produced between

the consumer in the patient role and the clinician. Co-creation is critically important in that it allows the organization and the customer to generate value mutually and contributes to structuring the service experience in a way that fits the customer's own context (Prahalad & Ramaswamy, 2004; Berkowitz, 2022). There are significant barriers to ensuring the participation of patients in co-production in healthcare services. Among the factors found to affect participation are mental health and psychological factors, as well as communication skills and physical abilities (Berkowitz, 2022). Therefore, the human component plays an important role in healthcare delivery and directly influences patients' perceptions.

Ravangard et al. (2020), in their study examining the effect of the service marketing mix on patients' hospital selection in healthcare services, found that all components had a significant effect on patients' hospital choice decisions. People (staff), physical evidence, and process factors emerged as the elements that most influenced patient preferences. It was determined that price also plays an important role in patients' hospital selection; however, factors related to service quality and experience were found to be more dominant.

Wooldridge and Camp (2018), in their study demonstrating the relationship between the healthcare service marketing mix in clinics and patient satisfaction, stated that the components of the service marketing mix in clinics—process, people, and physical evidence—are the most critical factors directly affecting customer satisfaction. Chana et al. (2021) found that the entire marketing mix plays a critical role in increasing patient satisfaction in clinical services, and that process is the most important predictor, followed respectively by people, price, product (services), physical evidence, and place (location). Only promotion was not found to significantly affect patient satisfaction.

Mardaleta et al. (2022) investigated the effect of internal service factors on service quality and patients' behavioral loyalty within hospitals. They revealed that patients' behavioral loyalty is determined by service quality, and that service quality is shaped by internal service factors such as the service provider, service process, and service environment, which together constitute the extended marketing mix. Huda and Yuliati (2022) found that hospitals' marketing mix strategies directly and indirectly affect patient loyalty, and that this effect is largely strengthened through patient satisfaction. It is emphasized that all elements of the marketing mix have significant effects on patient satisfaction and loyalty; however, the human and process dimensions are the factors with the strongest impact on satisfaction and loyalty. Furthermore, Astuti et al. (2025) concluded that the 7P marketing mix is a strategic tool for enhancing patients' behavioral loyalty and satisfaction, and that investments particularly in physical evidence, service processes, and personnel dimensions strengthen long-term commitment for healthcare organizations.

In conclusion, the literature shows that the 7P service marketing mix has been measured reliably and validly in healthcare services, as in other sectors. Therefore, in this study, the scale developed by Ravangard et al. (2020), which demonstrated high reliability and validity and concluded that all components have a significant effect on patients' hospital choice decisions, was adopted. This scale was used to examine the mediating effects of the marketing mix dimensions on patient experience and behavioral loyalty.

2.5. Research Gaps and Objectives

In the literature, there are numerous studies that address the relationship between patient experience and patient loyalty through elements such as trust, emotional bond, and communication (Alrubaiee & Alkaa'ida, 2011; Ladhari et al., 2017; Brandão & Ribeiro, 2023; Renaldo & Antonio, 2024; George & Sahadevan, 2024). Similarly, studies examining the relationship between service quality, satisfaction, and loyalty and analyzing in detail the effect of patient satisfaction on loyalty can also be found (Oliver et al., 1997; Chahal & Mehta, 2013; Addo et al., 2020; Mardaleta et al., 2022). In addition, there are studies that reveal the effects of the healthcare service marketing mix on satisfaction and loyalty (Wooldridge & Camp, 2018; Chana et al., 2021; Huda & Yuliati, 2022; Astuti et al., 2025) as well as those focusing on the effect of the service marketing mix on patients' hospital selection (Ravangard et al., 2020; Rahmawati & Susilowati, 2023).

Furthermore, the literature emphasizes that patient experience has significant effects on repurchase intention and behavioral loyalty (Klaus & Maklan, 2012; Kashif et al., 2016). Therefore, it is seen that the service marketing mix (7P) provides a critical framework for understanding patients' preferences and behaviors in healthcare services (Ravangard et al., 2020). Accordingly, it is observed that there are a limited number of models empirically testing patient experience, behavioral loyalty, and the service marketing mix together in healthcare services. For this reason, a comprehensive study analyzing not only the direct effects of experience quality on behavioral loyalty but also the

indirect effects emerging through the service marketing mix is considered to provide significant contributions to the literature. The findings obtained are expected to facilitate the decision-making processes of healthcare managers in developing patient-centered strategies, optimizing the components of the marketing mix, and enhancing patient loyalty with a holistic approach.

2.6. Research Model and Hypotheses

In this study, the Experience Quality Scale (EXQ) and the Service Marketing Mix were adopted as two fundamental theoretical frameworks to explain patients' perceptions and experiences regarding healthcare services. To evaluate more holistically how experience quality shapes individuals' behavioral tendencies, the variable of Behavioral Loyalty was also included in the model as the dependent variable.

The testing process of the model includes item analysis, internal consistency coefficients, composite reliability (CR), convergent and discriminant validity, and confirmatory factor analysis (CFA) steps to determine the validity and reliability of each construct. After confirming the measurement models, structural equation modeling (SEM) was applied to test the direct effects of experience quality on the marketing mix, the direct effects of the marketing mix on loyalty, and the indirect effects of experience quality on loyalty through the marketing mix.

In the model developed within the scope of the research, the subdimensions of EXQ—"Peace of Mind," "Outcome Focus," "Moments of Truth," and "Product Experience"—were defined as independent variables; the subdimensions of the 7P marketing mix (service, distribution, people, promotion, price, process, and physical evidence) as mediators; and behavioral loyalty as the dependent variable. The model is based on the assumption that patient loyalty is influenced not only by marketing strategies but also directly and indirectly by the quality of experiences patients have. In this context, the mediation models established were structured as follows:

Independent Variable		Mediator Variable		Dependent Variable
Experience Quality	→	Marketing Mix	→	Behavioral Loyalty
Experience Quality	→	7Ps (Service, Place, People, Promotion, Price, Process, Physical Evidence)	→	Behavioral Loyalty

Figure 1. Hypothetical Research Model

In the study, it is proposed that experience quality has a direct and positive effect on behavioral loyalty (H1) and also positively affects the healthcare service marketing mix (H2). In addition, it is assumed that the marketing mix has a direct positive effect on behavioral loyalty (H3) and plays a mediating role in the relationship between experience quality and behavioral loyalty (H4). Within this framework, regarding the 7P components of the marketing mix—service (H4a), distribution (H4b), people (H4c), promotion (H4d), price (H4e), process (H4f), and physical evidence (H4g)—it is hypothesized that each is positively influenced by experience quality, that these components have direct positive effects on behavioral loyalty, and that they simultaneously play a mediating role in the relationship between experience quality and behavioral loyalty.

3. Method

3.1. Type of Research and Data Collection Tool

This research was conducted as an explanatory study aiming to reveal the relationships among variables, based on the assumption that patient experience has an effect on behavioral loyalty and that the components of the healthcare service marketing mix (7Ps) play a mediating role in this effect. The survey method was used as the data collection technique, and a quantitative approach was adopted.

The research data were collected through a questionnaire form consisting of structured and closed-ended questions. The questionnaire form was delivered to participants via online platforms. Before the data collection process began, an informed consent form was presented to the participants to ensure full compliance with participant rights, confidentiality, and ethical principles.

The questionnaire form used in the study started with warm-up questions and consisted of three main sections. In the first section, the scale developed by Ravangard et al. (2020), which includes questions measuring the effect of the marketing mix on hospital preference, was used. In the second section, the version of the Customer Experience Quality (EXQ) Model developed by Klaus and Maklan (2012) and adapted to healthcare services by Kashif et al. (2016) was included. The Behavioral Loyalty Scale developed in the same study by Kashif et al. (2016) was also included in this section of the questionnaire. Finally, the third section contained demographic questions regarding participants' age, gender, education level, and income level. All scale items were arranged on a five-point Likert scale (1 = Strongly Disagree, 5 = Strongly Agree).

During the development of the questionnaire form, an additional statement was included in the "distribution" dimension of the marketing mix scale based on findings obtained from in-depth interviews conducted with a patient group of eight people (four women and four men) through open-ended questions. The added statement was: "The hospital's number of branch clinics or outpatient facilities is adequate."

In the language validity process, two experts in the field independently translated the scale items from English to Turkish, and a common Turkish version was created through comparison. This version was then translated back into English by an independent translator (back translation) to assess semantic consistency, and necessary revisions were made by comparing it with the original scale. The final version of the scale was sent to 16 experts for evaluation in terms of language and content; the experts rated each item on a five-point Likert scale. Based on 68 responses obtained from the experts, reliability analysis was conducted, and the intraclass correlation coefficient (ICC) was found to be 0.965 (95% CI = 0.933–0.987) using two-way ANOVA. This high value and the F-test result ($F = 13.733$; $p < 0.001$) indicated a high level of consistency among expert opinions. The results demonstrated that the scale achieved language validity and that the measurements were reliable and reproducible.

3.2. Population and Sample

The population of the research consists of individuals aged 18 and over who have received inpatient or outpatient healthcare services from different types of hospitals (public, private, university, and others) across Turkey. Since it was not practically possible to reach all individuals in the main population, the convenience sampling method was used to determine the sample. Accordingly, data were collected from a total of 460 individuals who voluntarily agreed to participate in the study.

3.3. Data Analysis

The data were analyzed using the R 4.4.2 program. In presenting descriptive statistics, frequency, percentage, mean, standard deviation, median, and quartiles were used. The assumption of normality was evaluated based on whether the skewness and kurtosis values of the variables remained between -1 and +1. The assumption of homoscedasticity was tested using Levene's test, and the Ramsey RESET test was used for the assumption of linearity.

In correlation analyses, Pearson and Spearman correlation coefficients were utilized depending on the distribution characteristics of the variables. For difference analyses, Independent Samples t-test and Mann–Whitney U test were applied for two-group comparisons; one-way analysis of variance (ANOVA) and Kruskal–Wallis H test were used for comparisons involving more than two groups. In post-hoc analyses, LSD, Games–Howell, and Dunn's tests were used to examine intergroup differences in detail.

In mediation analyses, the Bootstrap technique (with 5000 samples), Sobel test, and non-linear structural equation modeling with path analysis were applied to test direct and indirect effects. Confirmatory Factor Analysis (CFA) was used to assess convergent validity, and the robust maximum likelihood (robust ML) estimation method was preferred. Furthermore, the Fornell–Larcker criterion and the Average Variance Extracted (AVE) value were calculated to evaluate discriminant validity between latent constructs.

As part of the reliability analyses, Composite Reliability (CR), Cronbach's Alpha, McDonald's Omega, Guttmann's G6 coefficients, and the Signal-to-Noise ratio were calculated. In addition, in the item analysis, each item's raw item-test correlations and item-total correlations were examined.

In all analyses, the level of significance was interpreted at a 5% error rate.

3.4. Research Ethics

For the questionnaire form used in the study, ethics committee approval was obtained from the Rectorate of Istanbul Ticaret University, dated 31.01.2025 and numbered E65836846-044-344215. Participants were informed based on voluntary participation, and data were collected in accordance with confidentiality principles.

4. Testing the Research Model and Findings

Table 1 presents the sociodemographic characteristics of the 460 participants and the distribution of their preferences regarding healthcare services.

Table 1. Sociodemographic Characteristics of Participants and Distribution of Preferences Regarding Health Services

	n	%
Gender		
Female	283	61,52
Male	177	38,48
Age Range		
18-24	50	10,87
25-44	197	42,83
45-64	190	41,3
65 and above	23	5
Educational Status		
High school and below	142	30,87
University	205	44,57
Master's/Doctorate	113	24,57
Income Level		
0 - 25.000 TL	76	16,52
25.001 - 50.000 TL	184	40
50.001 TL and above	200	43,48
Social Security		
SGK	308	66,96
Private insurance	129	28,04
Paid patient	23	5
General Health Service Experience		
Poor	18	3,91
Moderate	148	32,17
Good	224	48,7
Very good	70	15,22
Received Health Service in the Last Year		
Yes	446	96,96
No	14	3,04
Most Important Factor When Receiving Health Service		
Physician quality	266	57,83
Fast service	104	22,61
Staff interest	66	14,35
Cleanliness of physical environment	18	3,91
All equally important	6	1,3
Primary Criterion When Choosing a Healthcare Institution		
Location (proximity)	133	28,91
Physician reputation	8	1,74
Institution reputation	164	35,65
Recommendation	79	17,17
Price/Payment/Insurance	76	16,52
Type of Hospital Usually Preferred		
Private hospital	232	50,43
Public hospital	176	38,26
University hospital	52	11,3
Type of Service Received from the Preferred Hospital		
Inpatient treatment	90	19,57

Outpatient health service (Polyclinic, emergency service, etc.)	370	80,43
Total	*460*	*100*

The majority of the participants are female, within the age range of 25–64, and university graduates. Their income levels are mostly at medium and high levels. A significant portion of the participants are covered by social security (SGK) and generally evaluated their healthcare service experiences as "good." Physician quality stands out as the most decisive factor in receiving healthcare services, while institutional reputation and location are the most prominent factors in the choice of healthcare institution. The preferred type of hospital is mostly private hospitals, and the type of service received is predominantly outpatient services.

Table 2. Item Analysis of the Marketing Mix 7P Scale

	Drop Alpha	**Raw item–test correlation**	**Item–total correlation**	**Mean**	**Std. Deviation**	Strongly Disagree (%)	Disagree (%)	Neutral (%)	Agree (%)	Strongly Agree (%)
Service1	0,96	0,65	0,63	3,8	1,05	0,05	0,08	0,12	0,52	0,23
Service2	0,96	0,7	0,69	3,6	1	0,04	0,1	0,2	0,51	0,15
Service3	0,96	0,66	0,64	3,6	1,07	0,04	0,12	0,25	0,38	0,2
Service4	0,96	0,66	0,64	3,4	1,1	0,07	0,13	0,24	0,41	0,15
Service5	0,96	0,63	0,61	3,4	1,05	0,06	0,1	0,32	0,38	0,14
Service6	0,96	0,53	0,5	3,2	1,02	0,07	0,16	0,42	0,26	0,1
Service7	0,96	0,59	0,56	3,2	1,03	0,07	0,13	0,4	0,3	0,1
Service8	0,96	0,62	0,59	3,2	1,14	0,1	0,15	0,23	0,41	0,1
Service9	0,96	0,63	0,61	3,3	1,1	0,07	0,13	0,32	0,34	0,14
Distribution1	0,96	0,48	0,45	3,6	1,17	0,08	0,1	0,17	0,43	0,22
Distribution2	0,96	0,55	0,53	3,6	1,01	0,05	0,1	0,18	0,51	0,16
Distribution3	0,96	0,57	0,55	3,3	0,89	0,03	0,13	0,48	0,28	0,08
Distribution4	0,96	0,48	0,46	3,3	1,04	0,07	0,14	0,33	0,37	0,1
Personnel1	0,96	0,57	0,55	3,4	1,12	0,08	0,14	0,22	0,43	0,13
Personnel2	0,96	0,67	0,65	3,3	1,03	0,06	0,15	0,31	0,39	0,09
Personnel3	0,96	0,7	0,68	3,4	1,03	0,06	0,12	0,3	0,4	0,13
Personnel4	0,96	0,68	0,66	3,4	1,09	0,07	0,13	0,28	0,39	0,13
Personnel5	0,96	0,7	0,68	3,4	1,05	0,06	0,12	0,28	0,42	0,12
Personnel6	0,96	0,67	0,65	3,7	1,1	0,06	0,1	0,17	0,45	0,22
Personnel7	0,96	0,69	0,67	3,7	1,05	0,06	0,08	0,2	0,47	0,19
Personnel8	0,96	0,63	0,61	3,5	1,07	0,06	0,11	0,25	0,42	0,16
Personnel9	0,96	0,66	0,64	3,6	1,05	0,06	0,09	0,2	0,47	0,18
Promotion1	0,96	0,66	0,64	3,7	1,06	0,06	0,06	0,22	0,45	0,21
Promotion2	0,96	0,56	0,54	3,4	1	0,05	0,11	0,37	0,35	0,12
Promotion3	0,96	0,66	0,64	3,4	0,97	0,04	0,12	0,35	0,38	0,11
Promotion4	0,96	0,53	0,51	3,2	1,04	0,06	0,18	0,34	0,33	0,1
Promotion5	0,96	0,57	0,55	3,2	1,01	0,07	0,13	0,42	0,29	0,09
Promotion6	0,96	0,51	0,49	3,1	1,08	0,09	0,16	0,4	0,25	0,1
Promotion7	0,96	0,56	0,53	3,2	1,04	0,07	0,16	0,38	0,29	0,1
Price1	0,96	0,39	0,36	3,2	1,16	0,09	0,17	0,28	0,32	0,13
Price2	0,96	0,59	0,56	3,5	1,05	0,06	0,08	0,27	0,43	0,15
Price3	0,96	0,36	0,33	3	1,01	0,08	0,17	0,45	0,23	0,07
Price4	0,96	0,62	0,6	3,4	1,01	0,05	0,11	0,33	0,39	0,13
Price5	0,96	0,38	0,35	3,3	1,11	0,09	0,12	0,36	0,3	0,13
Process1	0,96	0,64	0,61	3,4	1,11	0,08	0,1	0,26	0,42	0,14
Process2	0,96	0,71	0,69	3,3	1,02	0,06	0,13	0,35	0,36	0,11
Process3	0,96	0,71	0,69	3,4	1,01	0,05	0,11	0,3	0,42	0,11
Process4	0,96	0,7	0,69	3,4	1,06	0,07	0,1	0,3	0,4	0,13
Process5	0,96	0,68	0,66	3,4	1,08	0,07	0,11	0,28	0,41	0,13

Physical_Evidence1	0,96	0,55	0,53	3,6	1,08	0,07	0,09	0,21	0,47	0,17
Physical_Evidence2	0,96	0,64	0,62	3,6	0,95	0,03	0,09	0,24	0,49	0,14
Physical_Evidence3	0,96	0,6	0,58	3,7	0,96	0,03	0,07	0,25	0,47	0,17
Physical_Evidence4	0,96	0,47	0,44	3,3	1,16	0,1	0,15	0,28	0,34	0,13
Physical_Evidence5	0,96	0,69	0,67	3,6	1,02	0,05	0,09	0,24	0,47	0,15
Physical_Evidence6	0,96	0,69	0,67	3,6	1,06	0,06	0,1	0,23	0,46	0,15
Cronbach Alpha: 0,96	**G6:** 0,98	**Mean ± Std. Deviation:** 3,4±0,62			**S/N:** 25	**Avg. r:** 0,34			**Med. r:** 0,33	

The item analysis results of the Marketing Mix 7P Scale indicate that the scale has high internal consistency (Cronbach's Alpha = 0.96; Guttman G6 = 0.98). Most of the item-test and item-total correlations are above 0.40, showing that the scale functions coherently as a whole. The mean item scores range between 3 and 3.8, and the standard deviations are approximately around 1, indicating sufficient variance among respondents. The average inter-item correlation (0.34) and median correlation (0.33) values demonstrate adequate item homogeneity, while the Signal-to-Noise ratio (S/N = 25) reveals strong construct validity. The findings indicate that there is no need to remove any item from the scale. The Cronbach's Alpha values for the subdimensions were found to be Service (0.893), Distribution (0.738), People (0.910), Promotion (0.877), Price (0.787), Process (0.878), Physical Evidence (0.851), and Service Experience (0.685), and it was determined that all dimensions have an acceptable level of internal consistency. It was concluded that the reliability of the scale at both the overall and subdimension levels is satisfactory.

Table 3. Item Analysis of the Experience Quality Scale

	Drop Alpha	**Raw item–test correlation**	**Item–total correlation**	**Mean**	**Std. Deviation**	Strongly Disagree (%)	Disagree (%)	Neutral (%)	Agree (%)	Strongly Agree (%)
Peace_of_Mind1	0,93	0,67	0,62	3,70	0,98	0,04	0,05	0,24	0,47	0,19
Peace_of_Mind2	0,93	0,73	0,69	3,60	0,91	0,03	0,08	0,23	0,53	0,13
Peace_of_Mind3	0,93	0,69	0,65	3,50	0,94	0,03	0,11	0,33	0,42	0,12
Peace_of_Mind4	0,93	0,71	0,67	3,60	0,95	0,03	0,09	0,25	0,48	0,15
Peace_of_Mind5	0,93	0,72	0,68	3,50	1,03	0,05	0,12	0,25	0,45	0,15
Peace_of_Mind6	0,93	0,60	0,54	3,30	1,00	0,05	0,14	0,40	0,3	0,12
Moment_of_Truth1	0,93	0,67	0,62	3,40	1,08	0,08	0,11	0,30	0,39	0,12
Moment_of_Truth2	0,93	0,72	0,68	3,50	0,95	0,04	0,11	0,28	0,47	0,09
Moment_of_Truth3	0,93	0,74	0,7	3,50	0,99	0,04	0,11	0,28	0,43	0,14
Moment_of_Truth4	0,93	0,74	0,71	3,50	1,01	0,05	0,12	0,28	0,44	0,12
Moment_of_Truth5	0,93	0,73	0,69	3,40	1,05	0,06	0,11	0,35	0,35	0,13
Outcome_Focus1	0,93	0,74	0,7	3,40	1,03	0,06	0,09	0,32	0,40	0,13
Outcome_Focus2	0,93	0,82	0,79	3,50	0,96	0,04	0,09	0,32	0,43	0,12
Outcome_Focus3	0,93	0,71	0,67	3,50	0,97	0,04	0,09	0,32	0,42	0,13
Outcome_Focus4	0,93	0,76	0,73	3,50	0,99	0,05	0,09	0,32	0,42	0,13
Service_Experience1	0,93	0,53	0,46	3,50	1,12	0,08	0,08	0,25	0,42	0,16
Service_Experience2	0,93	0,60	0,55	3,60	0,94	0,03	0,10	0,26	0,47	0,15
Service_Experience3	0,93	0,56	0,51	3,50	1,00	0,03	0,13	0,27	0,42	0,15
Service_Experience4	0,94	0,46	0,38	3,00	1,20	0,13	0,22	0,25	0,29	0,10
Cronbach Alpha: 0,93	**G6:** 0,95	**Mean ± Std. Deviation:** 3,5±0,68			**S/N:** 14	**Avg. r:** 0,43			**Med. r:** 0,44	

The item analysis results of the Experience Quality Scale indicate that it has high internal consistency (Cronbach's Alpha = 0.93; Guttman G6 = 0.95). All raw item-test and item-total correlations are above 0.40. The mean item scores range between 3.0 and 3.7, and the standard deviations are approximately 1, indicating sufficient response variability. The average inter-item correlation was found to be 0.43, and the median correlation was 0.44; these values demonstrate that item homogeneity is adequate. The Signal-to-Noise ratio (S/N = 14) proves that construct validity is at a significant level. When subdimension reliabilities were examined, Peace of Mind (α = 0.864), Moments of Truth (α = 0.879), and Outcome Focus (α = 0.864) were found to be high, while Service Experience (α = 0.685) was at an acceptable level. As a result, it was determined that the scale is reliable both overall and at the subdimension level.

Table 4. Item Analysis of the Behavioral Loyalty Scale

	Drop Alpha	**Raw item–test correlation**	**Item–total correlation**	**Mean**	**Std. Deviation**	Strongly Disagree (%)	Disagree (%)	Neutral (%)	Agree (%)	Strongly Agree (%)
Behavioral_Loyalty1	0,87	0,81	0,65	3,50	1,07	0,07	0,1	0,22	0,46	0,15
Behavioral_Loyalty2	0,80	0,89	0,81	3,50	0,93	0,03	0,09	0,35	0,41	0,12
Behavioral_Loyalty3	0,83	0,86	0,74	3,50	0,99	0,05	0,1	0,3	0,43	0,11
Behavioral_Loyalty4	0,84	0,85	0,72	3,50	1,00	0,05	0,09	0,3	0,42	0,14
Cronbach Alpha: 0,87	**G6:** 0,85	**Mean ± Std. Deviation:** 3,5±0,85			**S/N:** 6,9	**Avg. r:** 0,63			**Med. r:** 0,68	

The item analysis of the Behavioral Loyalty Scale indicates that it has a high level of reliability (Cronbach's Alpha = 0.87; Guttman G6 = 0.85). The item–total correlations range between 0.65 and 0.81, showing that all items contribute strongly to the scale. The mean item scores are around 3.50, and the standard deviations range between 0.93 and 1.07. The drop-alpha values indicate that removing any item would decrease reliability. The average inter-item correlation is 0.63, and the median correlation is 0.68, showing high item homogeneity. The Signal-to-Noise ratio (S/N = 6.9) indicates that construct validity is at an acceptable level. The findings reveal that the scale has strong construct validity and high internal consistency. In all scales, the item–total correlations and drop-alpha values were found to be satisfactory and did not require item removal. Based on these reliability levels, convergent validity analysis was conducted.

Table 5. Convergent Validity of the Marketing Mix 7P Scale

	Factor Loadings	**R2**	**Average Variance Extracted (AVE)**	**Composite Reliability (CR)**	**Ω**
Service1	0,677	0,458	0,484	0,893	0,895
Service2	0,809	0,655			
Service3	0,764	0,584			
Service4	0,746	0,557			
Service5	0,715	0,511			
Service6	0,596	0,355			
Service7	0,644	0,415			
Service8	0,627	0,393			
Service9	0,669	0,448			
Distribution1	0,659	0,434	0,445	0,738	0,755
Distribution2	0,816	0,666			
Distribution3	0,625	0,391			
Distribution4	0,539	0,291			
Personnel1	0,562	0,316	0,535	0,910	0,912
Personnel2	0,719	0,517			
Personnel3	0,782	0,612			
Personnel4	0,763	0,582			

Personnel5	0,768	0,590			
Personnel6	0,718	0,516			
Personnel7	0,77	0,593			
Personnel8	0,741	0,549			
Personnel9	0,755	0,570			
Promotion1	0,514	0,264	0,516	0,877	0,880
Promotion2	0,749	0,561			
Promotion3	0,745	0,555			
Promotion4	0,731	0,535			
Promotion5	0,751	0,564			
Promotion6	0,751	0,564			
Promotion7	0,769	0,591			
Price1	0,632	0,400	0,424	0,787	0,790
Price2	0,643	0,413			
Price3	0,66	0,436			
Price4	0,672	0,452			
Price5	0,654	0,428			
Process1	0,635	0,403	0,597	0,878	0,882
Process2	0,758	0,575			
Process3	0,856	0,733			
Process4	0,836	0,699			
Process5	0,78	0,609			
Physical_Evidence1	0,668	0,446	0,493	0,851	0,859
Physical_Evidence2	0,798	0,637			
Physical_Evidence3	0,756	0,572			
Physical_Evidence4	0,524	0,274			
Physical_Evidence5	0,761	0,579			
Physical_Evidence6	0,736	0,541			

The factor loadings of the Marketing Mix 7P Scale range between 0.51 and 0.86, indicating that the items significantly explain their respective factors. The explained variance (R^2) values of the items are at a sufficient level; the average explained variance in the subdimensions ranges between 0.42 and 0.60, and the composite reliability values range between 0.74 and 0.91. McDonald's Omega values are above 0.75 for all factors. According to the Fornell–Larcker criterion, the square root of each subdimension's AVE (0.65–0.77) is higher than its correlations with other subdimensions. The findings indicate that the scale has high convergent and discriminant validity as well as strong internal consistency, demonstrating that the 7P dimensions can be confidently used in research.

Table 6. Convergent Validity of the Experience Quality Scale

	Factor Loadings	**R2**	**Average Variance Extracted (AVE)**	**Composite Reliability (CR)**	**Ω**
Peace_of_Mind1	0,673	0,452	0,521	0,864	0,867
Peace_of_Mind2	0,788	0,620			
Peace_of_Mind3	0,743	0,552			
Peace_of_Mind4	0,764	0,584			
Peace_of_Mind5	0,753	0,567			
Peace_of_Mind6	0,609	0,370			
Moment_of_Truth1	0,697	0,485	0,592	0,879	0,881
Moment_of_Truth2	0,774	0,599			
Moment_of_Truth3	0,803	0,645			
Moment_of_Truth4	0,801	0,642			
Moment_of_Truth5	0,781	0,610			
Outcome_Focus1	0,742	0,551	0,617	0,864	0,866
Outcome_Focus2	0,87	0,757			
Outcome_Focus3	0,742	0,551			
Outcome_Focus4	0,788	0,620			

Service_Experience1	0,725	0,525	0,586	0,796	0,815
Service_Experience2	0,903	0,816			
Service_Experience3	0,675	0,456			
~~Service_Experience4~~	~~0,254~~[a]	~~0,065~~[a]			

a: Value in the model before deletion.

The fourth item of the service experience subdimension was removed because its factor loading (0.254) and explained variance ratio (R^2 = 0.065) were below the thresholds. The factor loadings of the remaining items range between 0.61 and 0.90, sufficiently explaining their respective factors. The average explained variance by factor ranges between 0.52 and 0.62, composite reliability values range between 0.80 and 0.88, and McDonald's Omega values are above 0.81. According to the Fornell–Larcker discriminant validity criterion, the square root of each subdimension's AVE (0.72–0.79) is higher than its correlations with other factors. This indicates that each dimension represents a distinct construct. These findings demonstrate that the scale has high convergent and discriminant validity and internal consistency and that it can be confidently used to measure patient experience with the remaining items.

Table 7. Convergent Validity of the Behavioral Loyalty Scale (Single Factor)

	Factor Loadings	R2	Average Variance Extracted (AVE)	Composite Reliability (CR)	Ω
Behavioral_Loyalty1	0,721	0,520	0,631	72,7	0,876
Behavioral_Loyalty2	0,885	0,783			
Behavioral_Loyalty3	0,809	0,654			
Behavioral_Loyalty4	0,779	0,607			

The factor loadings of the Behavioral Loyalty Scale range between 0.72 and 0.89, and all items are highly explained by the factor. The explained variance ratios (R^2) range between 0.52 and 0.78, and the average explained variance is 0.63. In the single-factor structure, 72.7% of the total variance is explained, and McDonald's Omega is 0.88, indicating a high level of internal consistency. The findings show that the scale has convergent validity and reliability and can be used to measure the related construct.

According to the second-order confirmatory factor analysis results of the marketing mix (7P) scale, all items are significantly loaded on their respective factors, with standardized factor loadings ranging between 0.40 and 0.89. It was observed that the seven subfactors (Service, Distribution, People, Promotion, Price, Process, and Physical Evidence) were significantly grouped under the higher-order "Marketing Mix" factor. All standard error values of the loadings are low, and the t-test (z) results are significant at the $p<0.001$ level. The loadings are higher in the People, Service, and Process factors, while some items in the Price and Distribution dimensions are relatively lower. The second-order factor loadings indicate that all subfactors are strongly correlated with the higher-order factor and that the structure is consistent with theoretical expectations. The R^2 values of the items range between 0.16 and 0.61 and are mostly at a sufficient level. The findings show that the items and subfactors adequately represent the higher-order structure, support the hierarchical construct validity of the scale, and indicate that there is no need for item removal. Modifications were made only among variables within the factors, and all produced significant covariance relationships.

Table 8. Fit Indices of the Marketing Mix 7P Scale

Fit Index	Obtained Value	Acceptable Range (Good Value)	Interpretation
χ^2/df	1,999	< 5 (iyi: <2)	Acceptable
Robust CFI	0,916	> 0.90 (iyi: >0.95)	Acceptable
Robust TLI	0,906	> 0.90 (iyi: >0.95)	Acceptable
RMSEA	0,051	< 0.08 (iyi: <0.06)	Good fit
SRMR	0,053	< 0.08 (iyi: <0.05)	Acceptable
GFI	0,797	> 0.90 (iyi: >0.95)	Below the threshold
AGFI	0,763	> 0.85 (iyi: >0.90)	Below the threshold

The fit indices reveal that the second-order confirmatory factor analysis model demonstrates a good level of fit. The χ^2/df ratio is 1.999, indicating an excellent fit between the model and the data. The robust CFI (0.916) and TLI (0.906) values are above the 0.90 threshold. RMSEA (0.051) indicates a good fit with a low level of error, while SRMR (0.053) reflects that the model's covariance structure fits the data at an acceptable error level. These findings support that the seven subfactors (Service, Distribution, People, Promotion, Price, Process, Physical Evidence) are meaningfully grouped under the higher-order Marketing Mix factor and that the hierarchical structure is consistent with the data. Although the GFI (0.797) and AGFI (0.763) values are below the recommended threshold, these indices are of secondary importance in the robust MLR approach. RMSEA, CFI, TLI, and SRMR are the main fit criteria. As a result, the second-order factor structure confirmed the theoretical structure of the scale and demonstrated that hierarchical construct validity was achieved.

According to the second-order confirmatory factor analysis results of the Experience Quality Scale, all items are significantly loaded on their respective factors, with standardized factor loadings ranging between 0.58 and 0.97. All loadings have low standard error values, and the z-test results are significant at the $p<0.001$ level. The four subfactors are strongly clustered under the higher-order Experience Quality factor; the factor loadings and explained variance values indicate that the higher-order construct is consistent with theoretical expectations. The Behavioral Loyalty Scale was successfully modeled with four items, and the factor loadings were found to be high. Modifications were made only among variables within the factors, and all produced significant covariance relationships. The explained variance values (R^2: 0.27–0.77) are at a sufficient level. The findings show that all items adequately represent their respective factors, the subfactors sufficiently represent the higher-order Experience Quality construct, hierarchical construct validity is supported, and no item removal is necessary.

Table 9. Fit Indices of the Experience Quality Scale

Fit Index	Obtained Value	Acceptable Range (Good Value)	Interpretation
χ^2/df	2,719	< 5 (iyi: <2)	Acceptable
Robust CFI	0,930	> 0,90 (iyi: >0,95)	Acceptable
Robust TLI	0,914	> 0,90 (iyi: >0,95)	Acceptable
RMSEA	0,071	< 0,08 (iyi: <0,06)	Acceptable
SRMR	0,051	< 0,08 (iyi: <0,05)	Acceptable
GFI	0,855	> 0,90 (iyi: >0,95)	Below the threshold
AGFI	0,805	> 0,85 (iyi: >0,90)	Below the threshold

The fit indices of the Experience Quality Scale show that the model has an acceptable level of fit. The χ^2/df ratio of 2.719 is within the acceptable range. The robust CFI (0.930) and TLI (0.914) values are above the 0.90 threshold. The RMSEA (0.071) and SRMR (0.051) values are also within acceptable limits. Although the GFI (0.855) and AGFI (0.805) values are below the lower threshold, these indices are of secondary importance in the robust MLR approach. The appropriateness of the RMSEA, CFI, TLI, and SRMR values indicates that the model demonstrates a satisfactory structural and statistical fit.

Table 10. Descriptive Statistics and Alpha Values of the Scores Obtained from the Scales by Participants

Factor	Minimum	Maximum	Mean	Standard Deviation	Cronbach's Alpha
Service	1,00	5,00	3,43	0,78	0,893
Distribution	1,00	5,00	3,45	0,77	0,738
People	1,00	5,00	3,48	0,82	0,910
Promotion	1,00	5,00	3,32	0,78	0,877
Price	1,00	5,00	3,30	0,79	0,787
Process	1,00	5,00	3,40	0,86	0,878
Physical Evidence	1,00	5,00	3,54	0,79	0,851
Marketing Mix	**1,00**	**5,00**	**3,42**	**0,63**	**0,961**
Peace of Mind	1,00	5,00	3,55	0,75	0,864
Moment of Truth	1,00	5,00	3,44	0,83	0,879
Outcome Focus	1,00	5,00	3,48	0,83	0,864
Service Experience	1,00	5,00	3,54	0,86	0,796
Experience Quality	**1,00**	**5,00**	**3,50**	**0,69**	**0,936**
Behavioral Loyalty	**1,00**	**5,00**	**3,50**	**0,85**	**0,871**

The participants' mean factor scores range between 3.30 and 3.55. The Marketing Mix factor scored 3.42±0.63, the Experience Quality factor scored 3.50±0.69, and the Behavioral Loyalty Scale scored 3.50±0.85. The Cronbach's Alpha values of the subdimensions range between 0.738 and 0.910, indicating an acceptable level. The overall scores of the Marketing Mix (α=0.961) and Experience Quality (α=0.936) scales show very high internal consistency.

Table 11. Correlations Between the Scores Obtained from the Scales by Participants

	Distribution		People		Promotion		Price		Process		Physical Evidence		Marketing Mix		Peace of Mind		Moment of Truth		Outcome Focus		Service Experience		Experience Quality		Behavioral Loyalty	
	r	p	r	p	r	p	r	p	r	p	r	p	r	p	r	p	r	p	r	p	r	p	r	p	r	p
Service	0,399$_{sp}$	<0,001***	0,568$_{sp}$	<0,001***	0,519$_{sp}$	<0,001***	0,334$_{sp}$	<0,001***	0,554$_{sp}$	<0,001***	0,488$_{sp}$	<0,001***	0,731$_{sp}$	<0,001***	0,529$_{sp}$	<0,001***	0,474$_{sp}$	<0,001***	0,479$_{sp}$	<0,001***	0,269$_{sp}$	<0,001***	0,511$_{sp}$	<0,001***	0,416$_{sp}$	<0,001***
Distribution	1		0,410$_{sp}$	<0,001***	0,298$_{sp}$	<0,001***	0,343$_{sp}$	<0,001***	0,478$_{sp}$	<0,001***	0,420$_{sp}$	<0,001***	0,640$_{sp}$	<0,001***	0,412$_{sp}$	<0,001***	0,405$_{sp}$	<0,001***	0,397$_{sp}$	<0,001***	0,354$_{sp}$	<0,001***	0,470$_{sp}$	<0,001***	0,359$_{sp}$	<0,001***
People			1		0,485$_{sp}$	<0,001***	0,341$_{sp}$	<0,001***	0,601$_{sp}$	<0,001***	0,552$_{sp}$	<0,001***	0,779$_{sp}$	<0,001***	0,554$_{sp}$	<0,001***	0,596$_{sp}$	<0,001***	0,550$_{sp}$	<0,001***	0,292$_{sp}$	<0,001***	0,602$_{sp}$	<0,001***	0,468$_{sp}$	<0,001***
Promotion					1		0,385$_{pe}$	<0,001***	0,586$_{pe}$	<0,001***	0,392$_{sp}$	<0,001***	0,652$_{sp}$	<0,001***	0,433$_{sp}$	<0,001***	0,516$_{pe}$	<0,001***	0,514$_{pe}$	<0,001***	0,319$_{pe}$	<0,001***	0,449$_{sp}$	<0,001***	0,410$_{pe}$	<0,001***
Price							1		0,493$_{pe}$	<0,001***	0,338$_{sp}$	<0,001***	0,579$_{sp}$	<0,001***	0,324$_{sp}$	<0,001***	0,383$_{pe}$	<0,001***	0,429$_{pe}$	<0,001***	0,356$_{pe}$	<0,001***	0,372$_{sp}$	<0,001***	0,399$_{pe}$	<0,001***
Process									1		0,565$_{sp}$	<0,001***	0,809$_{sp}$	<0,001***	0,625$_{sp}$	<0,001***	0,669$_{pe}$	<0,001***	0,709$_{pe}$	<0,001***	0,474$_{pe}$	<0,001***	0,693$_{sp}$	<0,001***	0,616$_{pe}$	<0,001***
Physical Evidence											1		0,730$_{sp}$	<0,001***	0,504$_{sp}$	<0,001***	0,551$_{sp}$	<0,001***	0,492$_{sp}$	<0,001***	0,381$_{sp}$	<0,001***	0,577$_{sp}$	<0,001***	0,470$_{sp}$	<0,001***
Marketing Mix													1		0,660$_{sp}$	<0,001***	0,661$_{sp}$	<0,001***	0,654$_{sp}$	<0,001***	0,414$_{sp}$	<0,001***	0,726$_{sp}$	<0,001***	0,562$_{sp}$	<0,001***
Peace of Mind															1		0,609$_{sp}$	<0,001***	0,650$_{sp}$	<0,001***	0,333$_{sp}$	<0,001***	0,763$_{sp}$	<0,001***	0,563$_{sp}$	<0,001***
Moment of Truth																	1		0,743$_{pe}$	<0,001***	0,451$_{pe}$	<0,001***	0,826$_{sp}$	<0,001***	0,639$_{pe}$	<0,001***
Outcome Focus																			1		0,554$_{pe}$	<0,001***	0,867$_{sp}$	<0,001***	0,664$_{pe}$	<0,001***
Service Experience																					1		0,683$_{sp}$	<0,001***	0,486$_{pe}$	<0,001***
Experience Quality																							1		0,648$_{sp}$	<0,001***

pe: Pearson correlation; sp: Spearman correlation; *:p<0,05; **:p<0,01; ***:p<0,001

When examining the linear relationships between the participants' scores on the scales, statistically significant and positive correlations were found (p<0.001 for all correlations). Overall, moderate relationships were observed among the components of the marketing mix, with the correlations between the Service dimension and the People (r=0.568) and Process (r=0.554) dimensions being particularly prominent. The Distribution dimension showed the strongest relationships with the total Marketing Mix score (r=0.640) and the Process dimension (r=0.478). The People dimension was also found to have strong relationships with the Marketing Mix (r=0.779), Process (r=0.601), and Service Experience (r=0.602). The Promotion dimension exhibited notable correlations with the Marketing Mix (r=0.652) and Process (r=0.586) dimensions. The Price dimension had a moderate relationship with the Marketing Mix (r=0.579). The strongest correlation among the scales was observed between the Marketing Mix and the Process dimension (r=0.809). Additionally, the Marketing Mix showed strong relationships with experience components such as Peace of Mind (r=0.660), Outcome Focus (r=0.654), and Service Experience (r=0.726). Experience Quality exhibited very high correlations particularly with Outcome Focus (r=0.867), Moments of Truth (r=0.826), and Service Experience (r=0.683). Finally, Behavioral Loyalty showed positive and significant relationships especially with Experience Quality (r=0.648), Outcome Focus (r=0.664), Moments of Truth (r=0.639), Service Experience (r=0.486), and Peace of Mind (r=0.563).

Since significant and positive relationships were found among the scale scores, a mediation model was applied considering the correlated structure of the variables. The overall Marketing Mix score (the average of Distribution, People, Promotion, Price, Process, and Physical Evidence) was taken as the mediator; the overall Experience Quality score (the average of Peace of Mind, Moments of Truth, Outcome Focus, and Service Experience) was taken as the independent variable, and its effect on Behavioral Loyalty was tested using a bootstrap-based mediation analysis. In the first stage, the general model was examined, and in the second stage, the subdimensions of the Marketing Mix

were separately included as mediators in the structural equation modeling. Thus, after determining the general relationship, the analysis identified which marketing components were more decisive in the effect.

Before the analysis, the linearity assumption was examined using the Ramsey RESET test; in the model including the effect of Experience Quality on the Marketing Mix, a nonlinear relationship was detected (RESET = 13.577; $p<0.001$). Therefore, the square of Experience Quality (Experience_Quality^2) was added to the model. In the model including the effect of the Marketing Mix on Behavioral Loyalty, the linearity assumption was met (RESET = 1.825; $p=0.162$), while in the model including the direct effect of Experience Quality, a borderline value was obtained (RESET = 2.924; $p=0.055$). In line with these findings, both the linear and squared terms of Experience Quality were included in the model. Two regression models were defined in the mediation analysis: the mediator model (Marketing Mix ← Experience Quality + Experience Quality^2) and the outcome model (Behavioral Loyalty ← Experience Quality + Experience Quality^2 + Marketing Mix). Using the bootstrap method (n=5000 resamples), the indirect effect of Experience Quality on Behavioral Loyalty through the Marketing Mix was tested.

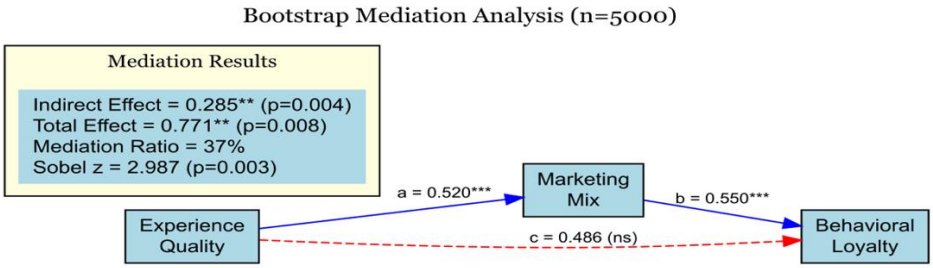

Figure 2. Full Mediation of the Marketing Mix in the Effect of Experience Quality on Behavioral Loyalty

The mediation effect of the Marketing Mix in the relationship between Experience Quality and Behavioral Loyalty was examined using a mediation analysis performed with the bootstrap method. The total effect of Experience Quality on Behavioral Loyalty was found to be positive and significant (Total Effect = 0.771, $p = 0.008$). Approximately 37% of this effect occurs indirectly through the Marketing Mix, and this indirect effect is also statistically significant (Indirect Effect = 0.285, $p = 0.004$). The Sobel test also confirmed that this indirect effect is significant ($z = 2.987$, $p = 0.003$). Examining the relationships along the structural path, the effect of Experience Quality on the Marketing Mix is positive and significant ($a = 0.520$; $p < 0.001$), and the effect of the Marketing Mix on Behavioral Loyalty is also positive and significant ($b = 0.550$; $p < 0.001$). In contrast, the direct effect of Experience Quality on Behavioral Loyalty became insignificant after the mediator was added to the model ($c' = 0.486$; $p = 0.064$).

Before the mediation model, the effect of the independent variable, Experience Quality, on the dependent variable, Behavioral Loyalty, was found to be positive and significant ($\beta = 0.648$; $p < 0.001$). This result supports the theoretically expected structure of the mediation analysis, and the fact that the direct effect of the independent variable lost its significance after the mediator variable was included in the model indicates that the effect was largely (37%) transmitted indirectly. This finding reveals that the intervening variable assumes a significant full mediation role. Accordingly, the Marketing Mix was found to play a critical enhancing mediating role in explaining the positive relationship between Experience Quality and Behavioral Loyalty.

Before conducting path analysis in the structural equation models, the Ramsey RESET test was applied to test the linear model assumption. Significant specification errors indicating nonlinear structures were detected for the effects of Experience Quality on the subdimensions of the Marketing Mix: Service ($p = 0.0006$), Distribution ($p = 0.0001$), People ($p = 0.0078$), Promotion ($p = 0.0031$), Price ($p = 0.0002$), and Physical Evidence ($p = 0.0023$). These results made it necessary to include quadratic or cubic terms in the respective models. Significant specification errors were also found in all models examining the effects of the Marketing Mix subdimensions on Behavioral Loyalty (all $p < 0.05$), indicating the presence of nonlinear interactions. In the model examining the direct effect of Experience Quality on Behavioral Loyalty, the RESET test result was borderline ($p = 0.0547$) and was considered linearly related. In light of these findings, squared and cubic terms were added to the structural equation modeling, and the mediation models were structured accordingly.

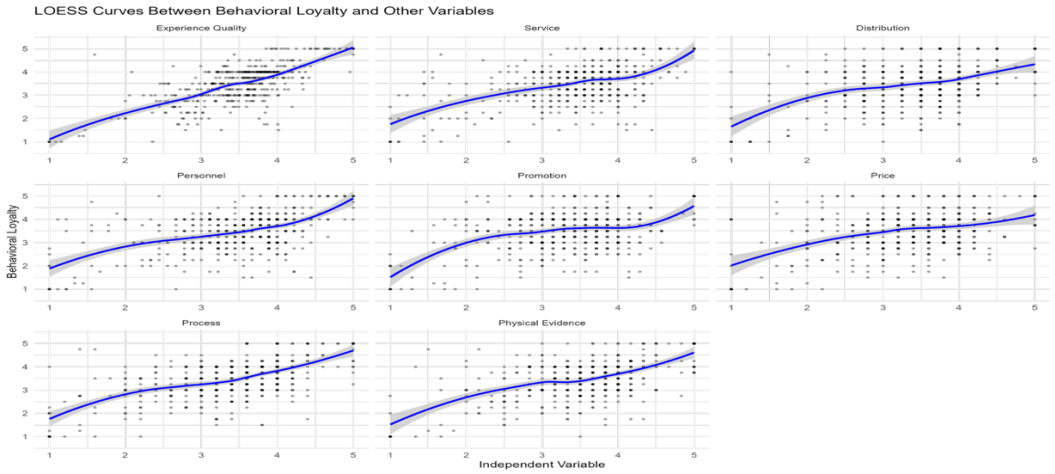

Figure 3. Nonlinear Relationships Between Behavioral Loyalty, Experience Quality, and the Sub-Dimensions of the Marketing Mix

According to the Ramsey RESET tests, the linear model was found to be inadequate for all variables except Experience Quality, and nonlinear structures were identified. Experience Quality was found to be consistent with the linear model in its relationship with Behavioral Loyalty (Quadratic p = 0.5373; Cubic p = 0.2661), and no polynomial term was added. In the other variables, especially the cubic structures were significant. The cubic models were significant, while the quadratic models were not, for Service (p = 0.0036), Distribution (p = 0.0010), Process (p = 0.0158), and Physical Evidence (p = 0.0043). For Promotion (quadratic p = 0.0034; cubic p < 0.0001) and Price (quadratic p = 0.0138; cubic p = 0.0075), both structures were significant, but the cubic models were stronger. In the People variable, the cubic structure was marginally significant (p = 0.0779), and therefore, the cubic model was preferred. The findings indicate that considering nonlinear relationships, particularly at the cubic level, in structural equation models will increase the model's validity.

Table 12. Results of the Nonlinear Structural Equation Model on the Direct Effect of Experience Quality on Behavioral Loyalty and Its Indirect Effects Through the 7Ps of Marketing

Parameter	Beta	Std. Beta	Std. Error	z	p
Service ← Experience Quality (a1)	**0,751**	**0,658**	**0,041**	**18,336**	**<0,001*****
Distribution ← Experience Quality (a2)	**0,656**	**0,581**	**0,048**	**13,793**	**<0,001*****
People ← Experience Quality (a3)	**0,818**	**0,687**	**0,040**	**20,682**	**<0,001*****
Promotion ← Experience Quality (a4)	**0,646**	**0,568**	**0,049**	**13,226**	**<0,001*****
Price ← Experience Quality (a5)	**0,546**	**0,476**	**0,054**	**10,107**	**<0,001*****
Process ← Experience Quality (a6)	**0,960**	**0,761**	**0,034**	**28,283**	**<0,001*****
Physical Evidence ← Experience Quality (a7)	**0,792**	**0,689**	**0,040**	**19,830**	**<0,001*****
Behavioral Loyalty ← Service (b1)	-0,336	-0,112	1,109	-0,303	0,762
Behavioral Loyalty ← Service² (b1_2)	0,153	0,317	0,353	0,435	0,664
Behavioral Loyalty ← Service³ (b1_3)	-0,019	-0,199	0,036	-0,517	0,605
Behavioral Loyalty ← Distribution (b2)	-0,136	-0,045	1,355	-0,101	0,920
Behavioral Loyalty ← Distribution² (b2_2)	0,020	0,042	0,403	0,049	0,961
Behavioral Loyalty ← Distribution³ (b2_3)	0,000	0,000	0,039	-0,001	0,999
Behavioral Loyalty ← People (b3)	0,681	0,238	1,015	0,671	0,502
Behavioral Loyalty ← People² (b3_2)	-0,279	-0,613	0,329	-0,848	0,396
Behavioral Loyalty ← People³ (b3_3)	0,035	0,400	0,035	1,011	0,312
Behavioral Loyalty ← Promotion (b4)	**2,261**	**0,754**	**0,975**	**2,319**	**0,020***
Behavioral Loyalty ← Promotion² (b4_2)	**-0,710**	**-1,483**	**0,311**	**-2,281**	**0,023***
Behavioral Loyalty ← Promotion³ (b4_3)	**0,069**	**0,742**	**0,032**	**2,153**	**0,031***
Behavioral Loyalty ← Price (b5)	-0,468	-0,157	0,997	-0,469	0,639
Behavioral Loyalty ← Price² (b5_2)	0,188	0,392	0,310	0,605	0,545
Behavioral Loyalty ← Price³ (b5_3)	-0,021	-0,222	0,031	-0,660	0,509
Behavioral Loyalty ← Process (b6)	-0,463	-0,171	1,037	-0,446	0,656

Behavioral Loyalty ← Process² (b6_2)	0,134	0,312	0,326	0,411	0,681
Behavioral Loyalty ← Process³ (b6_3)	-0,009	-0,113	0,033	-0,277	0,781
Behavioral Loyalty ← Physical Evidence (b7)	0,195	0,066	0,863	0,226	0,821
Behavioral Loyalty ← Physical Evidence² (b7_2)	-0,066	-0,147	0,273	-0,241	0,809
Behavioral Loyalty ← Physical Evidence³ (b7_3)	0,009	0,110	0,028	0,322	0,748
Indirect1 (Behavioral Loyalty ← Service)	*-0,252*	*-0,074*	*0,832*	*-0,303*	*0,762*
Indirect2 (Behavioral Loyalty ← Distribution)	*-0,089*	*-0,026*	*0,894*	*-0,100*	*0,920*
Indirect3 (Behavioral Loyalty ← People)	*0,557*	*0,163*	*0,828*	*0,673*	*0,501*
Indirect4 (Behavioral Loyalty ← Promotion)	***1,460***	***0,428***	***0,632***	***2,309***	***0,021****
Indirect5 (Behavioral Loyalty ← Price)	*-0,256*	*-0,075*	*0,545*	*-0,469*	*0,639*
Indirect6 (Behavioral Loyalty ← Process)	*-0,444*	*-0,130*	*0,987*	*-0,450*	*0,653*
Indirect7 (Behavioral Loyalty ← Physical Evidence)	*0,155*	*0,045*	*0,679*	*0,228*	*0,820*
Total Indirect Effect	1,130	0,331	0,735	1,539	0,124
Total Effect	**1,795**	**0,526**	**0,726**	**2,471**	**0,013***

The findings of the nonlinear structural equation model presented in Table 12 encompass a complex network of relationships in which the effects of experience quality on behavioral loyalty are examined both directly and indirectly through the 7P dimensions of marketing. The results obtained from the model clearly reveal that experience quality has highly significant and positive direct effects on all sub-dimensions of marketing (service, distribution, people, promotion, price, process, and physical evidence) (all $p<0.001$). The standardized beta coefficients for these relationships range between 0.476 and 0.761, indicating that the increase in experience quality has the strongest effect on "Process" (β=0.960; Std. Beta=0.761), followed by "People" (β=0.818; Std. Beta=0.687) and "Physical Evidence" (β=0.792; Std. Beta=0.689).

In explaining behavioral loyalty directly, it was notably found that only the "Promotion" dimension and its quadratic and cubic functions had significant effects ($p<0.05$). This indicates that promotion shows a nonlinear relationship with behavioral loyalty, suggesting the existence of a certain threshold or optimal level. The nonlinear effects of other marketing dimensions did not reach statistical significance, implying that these relationships may vary in more complex and different contextual frameworks.

Regarding indirect effects, only the mediation effect of the "Promotion" dimension was found to be significant ($Indirect_4$: β=1.460; Std. Beta=0.428; p=0.021), while the mediating roles of other dimensions were not significant. This mediating role of promotion strengthens the effect of experience quality on behavioral loyalty, making it an important strategic factor. Although the total indirect effect value (β=1.130; Std. Beta=0.331; p=0.124) alone did not reach statistical significance, the significance of the total effect obtained by adding the direct effect (β=0.664; Std. Beta=0.195; $p<0.001$) (β=1.795; Std. Beta=0.526; p=0.013) confirms the influential role of experience quality on behavioral loyalty. Accordingly, it was determined that experience quality has the potential to shape customer loyalty both directly and indirectly through the promotion dimension, while the other marketing dimensions may play a more limited role in terms of indirect effects.

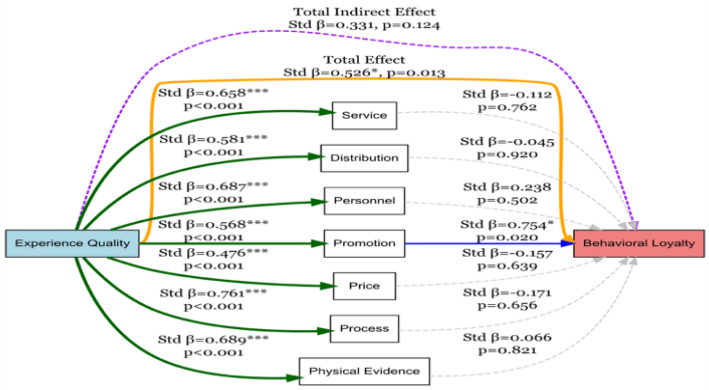

Figure 4. Path Diagram of the Direct, Indirect, and Total Effect Model of Experience Quality on Behavioral Loyalty through the Marketing Mix 7Ps

According to the path diagram, Experience Quality significantly predicts all seven components of the Marketing Mix (std β = 0.581–0.761; all $p<0.001$). However, among the direct effects of these seven components on Behavioral

Loyalty, only the Promotion variable was found to be significant and positively predicted behavioral loyalty (std β = 0.754; p = 0.020). In the indirect effect analyses, the indirect effect through Promotion was also found to be significant (std β = 0.428; p = 0.021), while the total indirect effect across all seven components remained below the threshold of statistical significance (std β = 0.331; p = 0.124).
The total effect of Experience Quality on Behavioral Loyalty was again determined to be positive and significant (std β = 0.526; p = 0.013). Accordingly, Experience Quality is an important direct determinant in strategies aimed at increasing Behavioral Loyalty, and within this relationship, it plays an effective indirect role particularly through the Promotion component.

Table 13. Mediating Effects of Marketing Mix Components in the Relationship Between Experience Quality and Behavioral Loyalty

Models	β	Standardized β	Standard Error	p	Mediation Ratio	Sobel z	Sobel p
EQ → S → BL							
Effect on Mediator (a)	0,751	0,658	0,042	<0,001***			
Effect of Mediator (b)	0,090	0,083	0,049	0,065			
Direct Effect (c')	0,827	0,668	0,060	<0,001***	7,6%	1,935	0,053
Indirect Effect (a×b)	0,068	0,055	0,037	0,068			
Total Effect (c)	0,895	0,722	0,044	<0,001***			
EQ → D → BL							
Effect on Mediator (a)	0,656	0,581	0,048	<0,001***			
Effect of Mediator (b)	0,050	0,045	0,044	0,254			
Direct Effect (c')	0,863	0,696	0,052	<0,001***	3,6%	1,139	0,255
Indirect Effect (a×b)	0,033	0,026	0,029	0,259			
Total Effect (c)	0,895	0,722	0,044	<0,001***			
EQ → P → BL							
Effect on Mediator (a)	0,818	0,687	0,041	<0,001***			
Effect of Mediator (b)	0,098	0,094	0,047	0,037*			
Direct Effect (c')	0,815	0,658	0,059	<0,001***	8,9%	2,111	0,035*
Indirect Effect (a×b)	0,080	0,065	0,039	0,040*			
Total Effect (c)	0,895	0,722	0,044	<0,001***			
EQ → Pr → BL							
Effect on Mediator (a)	0,646	0,568	0,050	<0,001***			
Effect of Mediator (b)	-0,000	-0,000	0,043	0,993			
Direct Effect (c')	0,896	0,723	0,053	<0,001***	0%	-0,009	0,993
Indirect Effect (a×b)	-0,000	-0,000	0,027	0,993			
Total Effect (c)	0,895	0,722	0,044	<0,001***			
EQ → Prc → BL							
Effect on Mediator (a)	0,546	0,476	0,055	<0,001***			
Effect of Mediator (b)	0,076	0,071	0,044	0,082			
Direct Effect (c')	0,854	0,689	0,051	<0,001***	4,7%	1,905	0,057
Indirect Effect (a×b)	0,042	0,034	0,024	0,088			
Total Effect (c)	0,895	0,722	0,044	<0,001***			
EQ → Pro → BL							
Effect on Mediator (a)	0,960	0,761	0,034	<0,001***			
Effect of Mediator (b)	0,155	0,157	0,058	0,007**			
Direct Effect (c')	0,747	0,603	0,075	<0,001***	16,6%	3,161	0,002**
Indirect Effect (a×b)	0,148	0,120	0,055	0,007**			
Total Effect (c)	0,895	0,722	0,044	<0,001***			
EQ → PE → BL							
Effect on Mediator (a)	0,792	0,689	0,040	<0,001***			
Effect of Mediator (b)	0,124	0,115	0,053	0,020*			
Direct Effect (c')	0,797	0,643	0,062	<0,001***	10,9%	2,569	0,010*
Indirect Effect (a×b)	0,098	0,079	0,043	0,022*			
Total Effect (c)	0,895	0,722	0,044	<0,001***			

EQ: Experience Quality; S: Service; D: Distribution; P: People; Pr: Promotion; Prc: Price; Pro: Process; PE: Physical Evidence; BL: Behavioral Loyalty; ACME: Indirect Effect; c': Direct Effect; *: p<0.05; **: p<0.01; ***: p<0.001

Table 13 provides a detailed examination of the mediating role of each marketing mix component in the effect of Experience Quality on Behavioral Loyalty.

When the effect of Experience Quality on Behavioral Loyalty through the Service component is examined, it is seen that Experience Quality significantly increases the perception of service ($\beta = 0.751$, $p < 0.001$). However, the effect of Service on Behavioral Loyalty is not significant ($\beta = 0.09$, $p = 0.065$). Therefore, the indirect effect shows borderline significance ($p = 0.068$), and the mediation rate is 7.60%. The Sobel test also supports this borderline situation ($z = 1.935$, $p = 0.053$). These findings indicate that the Service component mediates the effect of Experience Quality on Behavioral Loyalty at a partial and weak level.

Experience Quality significantly increases the perception of Distribution ($\beta = 0.656$, $p < 0.001$). However, the effect of Distribution on Behavioral Loyalty is statistically insignificant ($\beta = 0.05$, $p = 0.254$). Therefore, the indirect effect is not significant ($p = 0.259$), and the mediation rate is quite low at 3.60%. The Sobel test also confirms the absence of a mediating effect ($z = 1.139$, $p = 0.255$). Consequently, the Distribution component does not play a mediating role in enhancing Behavioral Loyalty.

Experience Quality significantly increases the perception of Personnel ($\beta = 0.818$, $p < 0.001$), and the effect of Personnel on Behavioral Loyalty is also significant ($\beta = 0.098$, $p = 0.037$). The indirect effect is statistically significant ($p = 0.040$), and the mediation rate is 8.90%. The Sobel test also supports the mediation ($z = 2.111$, $p = 0.035$). According to these findings, the Personnel component significantly mediates the effect of Experience Quality on Behavioral Loyalty in an enhancing direction.

The Promotion component is strongly influenced by Experience Quality ($\beta = 0.646$, $p < 0.001$); however, Promotion has no significant effect on Behavioral Loyalty ($\beta = 0.00$, $p = 0.993$). The indirect effect is zero ($p = 0.993$), and the mediation rate is 0%. The Sobel test results ($z = -0.009$, $p = 0.993$) also support this finding. Therefore, the Promotion component does not have a mediating role in increasing or decreasing Behavioral Loyalty.

Experience Quality increases the perception of Price ($\beta = 0.546$, $p < 0.001$), but the effect of Price on Behavioral Loyalty is not statistically significant ($\beta = 0.076$, $p = 0.082$). The indirect effect shows borderline significance ($p = 0.088$), and the mediation rate is 4.70%. The Sobel test also supports this weak effect at a borderline level ($z = 1.905$, $p = 0.057$). Consequently, the Price component may show a weak mediating effect in enhancing Behavioral Loyalty, but this effect is limited and should be interpreted with caution.

Experience Quality strongly increases the Process component ($\beta = 0.96$, $p < 0.001$), and the Process component significantly increases Behavioral Loyalty ($\beta = 0.155$, $p = 0.007$). The indirect effect is also statistically significant ($p = 0.007$), and the mediation rate is 16.60%, the highest among all. The Sobel test strongly supports this mediation ($z = 3.161$, $p = 0.002$). These findings reveal that the Process component significantly mediates the effect of Experience Quality on Behavioral Loyalty and is the strongest mediating variable.

Experience Quality significantly increases the perception of Physical Evidence ($\beta = 0.792$, $p < 0.001$), and the effect of Physical Evidence on Behavioral Loyalty is also significant ($\beta = 0.124$, $p = 0.020$). The indirect effect is significant ($p = 0.022$), and the mediation rate is 10.90%. The Sobel test ($z = 2.569$, $p = 0.010$) supports this mediation effect. Consequently, the Physical Evidence component plays a significant mediating role in enhancing Behavioral Loyalty, and this effect is moderately strong.

5. Discussion and Conclusion

This section discusses the findings related to the relationship between patient experience and behavioral loyalty, as well as the mediating role of the healthcare service marketing mix (7P), in light of the existing literature.

In the literature, the EXQ model developed by Klaus and Maklan (2013) to measure experience quality reveals the determining effect of the functional and emotional cues experienced by customers during the service process on loyalty. Kashif et al. (2016) adapted the EXQ scale to healthcare services and demonstrated that patient experience quality explains behavioral loyalty and recommendation intention beyond satisfaction. Similarly, in this study, in addition to the direct effect of patient experience on behavioral loyalty, it was determined that its indirect effect through the 7P marketing mix is significant. However, the inclusion of both public and private hospitals in the study limited the identification of differences specific to institution types.

Taylor and Baker (1994) revealed the fundamental role of service quality and satisfaction in purchase intentions; Chahal and Mehta (2013) found that physical care, physician and nursing services, and internal facilities are determinants of satisfaction and directly affect loyalty. Addo et al. (2020) confirmed the direct effect of service

quality on satisfaction and loyalty. Brandão and Ribeiro (2023) stated that trust, communication, personalization, and relationship management strengthen experience and loyalty in medical-aesthetic services, while Renaldo and Antonio (2024) concluded that this relationship occurs through reliability. Therefore, the finding obtained in this study that "patient experience has a significant and positive effect on behavioral loyalty" is parallel with the literature. This finding once again reveals that loyalty behavior in healthcare services is strengthened not only by service quality and satisfaction but also by patient experience, which consists of more comprehensive dimensions.

Focusing on the dimensions of the marketing mix in healthcare services, Siripipatthanakul and Chana (2021) stated that the service marketing mix creates satisfaction by adding value to patients; Astuti et al. (2025) revealed that physical evidence and process have a positive and significant effect on satisfaction and loyalty, but the effect of service, price, distribution, and promotion on loyalty occurs directly and not through satisfaction. Huda and Yuliati (2022) stated that all components of the marketing mix have significant effects on patient satisfaction and loyalty, but that the personnel and process components have the strongest effects on satisfaction and loyalty.

In this study, differently, experience quality was prioritized and the marketing mix was included as a mediating variable in the relationship between experience quality and loyalty. The findings showed that the 7P marketing mix plays a full mediating role in this relationship. In the model where the sub-dimensions of the service marketing mix were evaluated separately, the process dimension had the strongest mediation, followed by physical evidence and personnel dimensions as significant mediators; service and price were limited, promotion and distribution were not significant; however, in the analysis in which the entire service marketing mix was included in the model, promotion showed a strong indirect effect. These findings reveal that behavioral loyalty is essentially based on service quality and patient experience-oriented elements, and that promotion gains strategic importance only when evaluated together with other marketing elements. According to the results, developing holistic marketing mix practices aimed at improving patient experience is considered a fundamental requirement for ensuring sustainable loyalty.

The results of the study show that the process, which has the strongest mediation, and the physical evidence and personnel dimensions, which show significant mediation, are critical in creating loyalty in the patient experience–behavioral loyalty relationship. Similarly, previous studies (Wooldridge and Camp 2018; Ravangard et al. 2020; Chana et al. 2021; Huda and Yuliati 2022; Astuti et al. 2025) also show that process, personnel, and physical evidence create strong effects in ensuring patient satisfaction and loyalty. These findings are consistent with Donabedian's (1980) Structure–Process–Outcome model; the fact that process (the way the service is delivered) and structure (physical and organizational conditions) mediate between the health outcomes resulting from patient experience and loyalty provides strong empirical support linking service marketing theory with healthcare management literatüre.

As a result, the findings of the study support the market-oriented planning approach of Narver and Slater (1990) and Day (1994); they show that marketing mix strategies based on experience quality play a critical role for healthcare institutions in terms of sustainable competitive power, together with patient-centeredness and service innovation.

5.1 Theoretical and Managerial Implications

One of the most important contributions of the study to the literature is that it reveals the mediating role of the marketing mix in explaining the effect of experience quality on behavioral loyalty. Although the effects of the service marketing mix or experience quality on behavioral loyalty have been examined separately in the literature, studies that model these three concepts holistically are quite limited. In this respect, the study fills an important gap in the literature and demonstrates in detail the role of patient-centered strategies in creating loyalty.

The study also has important implications for practitioners. For healthcare managers, it is not sufficient to invest only in promotion or external communication activities. Focusing on the quality of the processes experienced by patients, the arrangements of the physical environment, and staff interactions will be a much more effective strategy in ensuring long-term patient commitment.

5.2 Limitations and Recommendations

This study also has some limitations. The study is limited to individuals receiving services in public and private hospitals in Turkey, and due to its cross-sectional design, causality relationships should be interpreted with caution. Future research may enable these relationships to be tested more deeply through studies conducted in different cultures and using longitudinal methods. Furthermore, findings can be compared by repeating the study in different

types of hospitals. In addition, the interaction of the marketing mix with new elements can be examined by including digital health dimensions (telehealth, patient portals, AI-supported applications) of patient experience into the model. This study provides significant theoretical and practical contributions to the patient-centered healthcare management literature by revealing the direct and indirect effects of patient experience on behavioral loyalty through the marketing mix. It also opens new areas of investigation for future research.

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