Cause-related marketing and service innovation in emerging country healthcare

Role of service flexibility and service climate

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Abstract

Purpose – The purpose of this paper is to identify the constituents of cause-related marketing (CRM) capabilities in the context of an emerging market healthcare sector, by incorporating the resource-based view alongside the dynamic capability perspective. Moreover, the authors aim to illustrate how the typologies of CRM capabilities help to achieve service innovation whilst taking into consideration the role of service flexibility (SF) and service climate.

Design/methodology/approach – The authors develop a research framework through a representative and novel case study in the Indian healthcare market by utilizing and analyzing the subject-specific literature. Furthermore, a quantitative survey of healthcare professionals was conducted to assess the relationships utilizing PLS–SEM.

Findings – After identifying the constituents of CRM capabilities, the study confirms the mediating mechanism of SF between CRM capabilities and service innovation. Furthermore, findings from the study suggest that service climate positively moderates the relationship between CRM capability and SF.

Research limitations/implications – The study was conducted in the emerging country healthcare market of India. Thus, the generalizability of the framework needs to be tested in a similar or contrasting context. Furthermore, the sample size for the study was limited to healthcare professionals, and the customer's perspective was missing.

Originality/value – This paper is a first step to identify the specific dimensions of CRM capability and explain it as a higher-order factor. The study further provides an integrative framework that includes CRM capability, service innovation, SF and service climate. More specifically, it enhances the understanding of the constituents of the CRM capabilities and their influence on service innovation.

Keywords Service innovation, Emerging markets, Service climate, Cause-related marketing (CRM) capability, Service flexibility

Paper type Research paper

1. Introduction

The rise of healthcare tourism in India has attracted the attention of scholars and practitioners in the context of developing cause-related marketing (CRM) capabilities and its consequences (NSSO, 2015; Russo, 2016). Within the healthcare domain, development of CRM is fairly recent (Brandão *et al.*, 2013), and entails a progression from a fulfillment of social responsiveness to organizing the operative processes for effective service delivery and value creation for every patient and citizens. In the current economic turbulent environment, healthcare firms are increasingly concerned about their ability to safeguard and balance both their economic balance and service innovation in terms of customer value propositions (Wagner, 2010). Thus, firms are essentially focusing on the development of

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service flexibility (SF) in order to cope with the challenges of a dynamic environment, whilst simultaneously being adaptive to customer expectations (Brozovic *et al.*, 2016).

Possessing CRM capabilities demonstrates the potential of the firm to carry out its social responsibilities as they seek to formulate marketing activities that are characterized by it contributing toward a designated cause (Christofi, Leonidou, Vrontis, Kitchen and Papasolomou, 2015; Christofi, Leonidou and Vrontis, 2015). Many authors argue that CRM capabilities are an important facet of marketing capabilities wherein a firm connects its corporate identity toward a range of significant social issues and causes through cooperative marketing (Roy, 2010; Russo, 2016; Christofi *et al.*, 2018). CRM capabilities thus concentrate on a specific cause supported by the firm or a specific service of the firm. In doing so, CRM capabilities integrate valuable resources into core activities to cope with dynamic market conditions and seek to create innovative services (Cadogan *et al.*, 2009; Christofi *et al.*, 2018). Furthermore, CRM capabilities of the firm provide an opportunity for service innovation through the use of social, environmental or sustainability drivers to create new working methods, new services or new market space (Husted and Allen, 2007).

Additionally, capabilities in the form of accumulated skills and expertise are also utilized in service innovation and value creation (Kindström *et al.*, 2013). It is argued that organizations need to develop capabilities to adapt to customer expectations and understand customer idiosyncrasies while constantly engaged in innovation and value creation processes (Itani *et al.*, 2019; Singh *et al.*, 2019; Scuotto *et al.*, 2017). The utilization of CRM capabilities also facilitates customer engagement and allows a customer-centric customized delivery (Duarte and Silva, 2018). CRM capabilities thereby help to understand customer needs, and provide prompter responses and thus make a firm more flexible. The bottom line then is that organizations that exhibit SF are in a better position to improve their ability to innovate services that meet customer's requirements (Gronroos and Ravald, 2010; Brozovic *et al.*, 2016). It is in this context then that we identity a scarcity of research in investigating whether possession of CRM capabilities helps developing SF whilst facing challenges of resource constraints in conducting service innovation.

Recent studies have extensively examined the role of service climate in affecting SF and innovativeness of the firm (Morgan *et al.*, 2014). The service climate permeates all levels of the firm and reflects how customer's expectations are being fulfilled (Rao-Nicholson and Khan, 2017). In the healthcare domain, service climate guarantees an improved service quality culture and this facilitates redesigning of services. Studies indicate the relationship of service climate with the notion of SF and found to have contributing roles in the service innovation of the firm (e.g. Russo, 2016). We further argue that underlying philosophies of CRM activities are strongly based upon the philanthropic behavior of the employees. This argument can be made on the basis that CRM practices of the firm require a climate to support the designated cause and motivate employees to work for the cause, whereby service climate exerts a positive influence on its cause-oriented and pro-social behavior (e.g. Christofi, Leonidou, Vrontis, Kitchen and Papasolomou, 2015; Hahn *et al.*, 2015).

Additionally, scholars have also suggested that CRM capabilities are nested within an intricate organizational system of interrelated and interdependent resources which also influences the process and activities to understand customer idiosyncrasies (Christofi *et al.*, 2013). Scholars have also tried to establish that CRM capabilities increase a firm's ability to cope with dynamic market conditions, accommodate customer philanthropic requirements and fulfill the requirements to redesign the services (e.g. Demetriou *et al.*, 2009). Prior research has recognized the benefits of developing CRM capabilities. For example, CRM validates firm's deliberation on cause support, adapts to customers' continually evolving needs and preferences, and seeks to create innovative services that have a meaningful societal impact (Tsai, 2009). Several authors have also emphasized the importance of CRM capability as an emerging paradigm in marketing and its performance outcomes such as

brand image and competitive advantage of the firm (Eteokleous *et al.*, 2016; Christofi *et al.*, 2018). However, it is still largely unclear what exactly constitutes CRM capabilities.

Based on the above rationale and critique of the topic, the current study is an attempt to address the following gaps in the extant CRM and service innovation literature. In doing so, we first, aim to explore how the CRM capabilities are developed in an emerging healthcare market. Second, we examine how healthcare firms in emerging market cope with today's service businesses turbulence and utilize CRM capabilities for service innovation. From the dynamic capability perspective, SF provides an organization-wide response mechanism and adapts to customer preferences. Despite the increasing interest of scholars and practitioners for developing SF across the value chain through the utilization of valuable resources and organizational capabilities (Tan and Sousa, 2015; Brozovic *et al.*, 2016), there is a need for better understanding of how the relationship between CRM capability and service innovation is affected by SF. Third, service innovation is achieved with the resources in the form of assets and skills acquired by the organizations (Christofi *et al.*, 2013; Kindström *et al.*, 2013), we suggest that service climate could affect SF and service innovation. Accordingly, we further contribute by investigating how service climate moderates the relationships between CRM capability, SF and service innovation in the emerging healthcare market.

Overall, the study contributes to an integrative framework of CRM capability to develop international CRM alliances. The findings of the study also contribute to CRM and service innovation literature that conjoins the field of CRM through SF and service climate. This paper also guides healthcare firms operating in an emerging market to develop SF and facilitate new service concepts that are locally adaptive and globally robust.

This paper is organized as follows. First, we review the literature of CRM capabilities and its linkage with service innovation. Second, we describe the importance of SF and service climate, and highlight the theoretical gap. This is followed by research methodology design. Thereafter, we discuss the key findings. Finally, we conclude the paper with relevant implications and limitations of our approach and directions for future research.

2. Theoretical background

The resource-based view (RBV) has traditionally argued that organizations utilize their valuable resources for superior performance (Barney, 1991). RBV theorists contend that organizations achieve sustainable performance due to possession of rare, valuable, non-imitable and non-substitutable resources (Newert, 2008). These resources include physical assets, firm processes, skills and knowledge, technological and reputational capital and brand image which provide efficiency and effectiveness. Furthermore, organizational capabilities in the form of skills and competencies are utilized by the firms to coordinate various firm activities that contribute to competitive advantage (Day, 2000). Thus, drawing on the tenets of RBV, scholars have argued that organizations recognize the importance of various resources for disseminating CRM activities and communicating brand-cause fit (Day, 2000; Christofi *et al.*, 2013). It has also been posited that a brand-cause fit is high if a brand and a social cause share alike values (Christofi *et al.*, 2014). Furthermore, RBV reveals that CRM capabilities are an integrative process of utilizing firm resources (e.g. employees, Information Technology (IT) assets and firm reputation) to carry out CRM campaigns that trigger positive attitudinal and behavioral tendencies of customers for supporting the cause (Day, 2000; Christofi *et al.*, 2013). Consequently, CRM capabilities, as an important facet of marketing capability, enhance credibility regarding the cause, reduce customer skepticism and positively affect the customer's decision to engage in CRM campaigns of the firm.

A growing body of literature further argues that improved performance under uncertainties of a higher order is a function of dynamic capabilities that are used in the mechanization of internal and external resources (e.g. Zahra *et al.*, 2006; Tan and Sousa, 2015).

Dynamic capabilities, often referred to as routines, embedded in the firm's processes that enable them to coordinate various activities effectively (Kindström *et al.*, 2013), wherein these DCs aim to reconfigure the resources and are therefore orient change successfully. Furthermore, it is also posited that they not only adapt to customer demand and market trends, but also generate operational flexibility to shape their environment and innovative services (Cadogan *et al.*, 2009; Teece, 2010).

2.1 CRM capability

In recent years, CRM has gained popularity as a promotional tool for marketers and fund raisers that helps underpin greater competitive advantage (Christofi *et al.*, 2013). CRM is an integral part of a portfolio of methods that firms could utilize to demonstrate their responsiveness to societies' heightened expectations (Sheikh and Rian, 2011). CRM can thus be largely argued to be an attempt to align social problems and organizational goals. Over the last decade, marketing literature has developed a body of knowledge on CRM capabilities (Tsai, 2009), drivers and consequences of CRM (Soana, 2011; Chatzoglou *et al.*, 2017), and techniques for the successful implementation of CRM (Christofi, Leonidou, Vrontis, Kitchen and Papasolomou, 2015; Christofi, Leonidou and Vrontis, 2015). The major focus of CRM research is centered on building relationships with the community (Alcaniz *et al.*, 2009), management of network between market and society (Duarte and Silva, 2018), cooperative and collaborative relationships with external organizations (Rajaguru and Jekanyika, 2013; Christofi, Leonidou and Vrontis, 2015) and utilization of organizational structure and cultural changes to improve operational efficiency (Roy, 2010). Researchers emphasize that CRM has the potential to improve the relationship with the community and positively influences brand image (Demetriou *et al.*, 2009). Some studies have reiterated the multi-dimensionality of CRM capability and suggest identifying what constitutes CRM (Eid, 2007; Christofi, Leonidou, Vrontis, Kitchen and Papasolomou, 2015; Christofi, Leonidou and Vrontis, 2015). Scholars have also pointed out the need for developing an industry-specific framework of CRM and its outcomes (Soana, 2011; Christofi *et al.*, 2018).

The importance of CRM capability has also attracted significant attention in several profit-based and not-for-profit organizations (Soana, 2011; Amato and Amato, 2012; Salehi *et al.*, 2018). However, there is scarce focus in the literature when it comes to developing CRM capabilities in credence services like healthcare. CRM, in healthcare, essentially entails fundamental approaches to fulfill a social responsibility, to provide appropriate services as part of a mix that is inclusive of social justice and values, and reduce a patient's suffering whilst spreading healthy behavior (Russo, 2016). Brandão *et al.* (2013) suggest that implementing CRM in healthcare is a difficult process due to the complexity in the design of services and hence requires a better understanding of the resources and capabilities to safeguard an economic balance. Healthcare firms are in greater need of an integration when it comes to the role of CRM alongside service quality and service environment in an attempt to continuously renew its relationships with society (Wagner, 2010). Firms are thus pushed to find a new basis for community satisfaction and values that sustain good health. As such, healthcare firms remain concerned when it comes to their clinical ability, sustained relationships and social accountability. Studies indicate that CRM in healthcare facilitates patient's needs and preferences, develops new services, whilst rapidly adjusts their supply to meet demand, and thus exhibits SF (Brandão *et al.*, 2013; Russo, 2016).

In an emerging economy context, such as India, CRM practices in healthcare have become an important attribute to attract customers both local and foreign. With the increase in the competition, healthcare providers are looking to explore trends and dynamics that have a positive impact on their business. Based on the above discussion, we argue that CRM in healthcare, in the Indian context, is treated as a strategic tool to attract customers and medical tourists by demonstrating their support to a designated cause and increased brand

image. International community visiting India for healthcare has led to increasing attention of scholars and practitioners for developing CRM capabilities and its consequences (NSSO, 2015; Russo, 2016).

2.2 Service flexibility

Recent perspectives on services as value creation (Gronroos and Ravald, 2010; Gronroos and Gummerus, 2014; Malik *et al.*, 2018) have implied the relevancy of SF as the precise mechanisms for adaptation to individual circumstances. SF is referred to as the ability to cope with uncertain customer requirements and deliver customized services rapidly (Brozovic *et al.*, 2016). It represents the capability to provide effective customer services and adjustment of process and activities to understand customer idiosyncrasies (Gronroos and Ravald, 2010). In a healthcare delivery environment, building and sustaining a service-oriented culture is important for improved performance. SF increases the responsiveness toward customers, thus attempting to reduce the variability and satisfy the customers. SF implies that healthcare firms must focus on their practices and procedures for customers value creation (Brandão *et al.*, 2013; Christofi *et al.*, 2018; Malik *et al.*, 2018). Firms that are connected with customer's emotions are adaptable to their needs and execute flexibility in the provisioning of services (Lin *et al.*, 2015). As a result, service deliveries become more customer-centric, adaptable and responsive, which facilitate responding to customer requirements and bring about changes in service design (Gronroos and Gummerus, 2014), and hence it can be argued that healthcare firms could develop the abilities to innovate and redesign services.

2.3 Service innovation

Service innovation refers to a set of practices that create value through improvements or new service proposals, service processes and model of service deliveries (Kindström *et al.*, 2013). Service innovation indicates the ability of service providers to develop services that lead to greater achievements and new advantages to meet customer's need and satisfaction. Researchers have depicted several types of service innovation such as major or radical innovation, new services for the currently served market, extension of service lines, service improvements and stylistically changing the appearance of service offerings that affects emotions and attitude of customers (Christofi *et al.*, 2014). Service blueprints are at times portrayed with service processes and aligned with the customer's viewpoint by adapting to customer requirements and executing a high degree of flexibility (Brozovic *et al.*, 2016). It can be argued that the process of a new idea generation and developing service concepts are simplified, unbiased and objectively defined. Healthcare provisions have a central concern to keep pace with new ideas and approaches that can be integrated into the extended line of services and improved offerings leading to a platform for creating new organizational values (Brandão *et al.*, 2013; Ostrom *et al.*, 2015). It is within this healthcare sector that Russo (2016) emphasizes that skills, professionalism, working methods and technologies should be scaled-up to match with new and innovative services for healthier lives and reduction in suffering from illnesses. In summary and based on the above discussion, it can be posited that innovation in healthcare firms improves the quality of services as well as appearance of service offerings that leads to an impact on customer emotions and attitude.

2.4 Service climate

Service climate is defined as "the employee perceptions of the practices, procedures, and behaviors that get rewarded, supported, and expected with regard to customer service and customer service quality" (Schneider *et al.*, 1998, p. 151). Service climate refers to as a climate of the firm centered on providing services to customers and behaviors of customer-oriented

services, and has a positive impact on work engagement (Barnes and Collier, 2013). Service climate permeates the work force and reflects how well employees perceive the firm as fulfilling their expectations. Therefore, service climate is a subset of organizational climate, wherein it represents shared perception of employees regarding the customer-related services of the firm. Researchers also believe that service climate is the degree to which management emphasizes service quality in all the firm activities (Hoang *et al.*, 2018). Schneider *et al.* (2009) described three important facets of service climate, which are customer orientation, management practices and customer feedback. Hence, we argue that firms need to develop a positive service climate and work environment that supports service quality and customer-oriented services (Patnaik *et al.*, 2018; Oliva *et al.*, 2019). Therefore, based on the above discussion, we can posit that service climate of a firm provides an environment that motivates its employees for cause-specific behavior, social connectivity and increased responsiveness.

3. Research design

The study adopts a mixed method of research design (Harrison and Reilly, 2011). The research integrates qualitative and quantitative methodologies in a two-stage design. This is referred to as a sequential exploratory strategy (Creswell, 2006) which is characterized by an initial qualitative phase of data collection and analysis, followed by a phase of quantitative data collection and analysis.

3.1 Study context

The study was conducted in an emerging healthcare market context of India. Similar to other emerging markets, Indian healthcare firms are representative as they have made remarkable efforts in service innovation (NSSO, 2015). India is among the top healthcare markets across the globe and is likely to remain a dominant force in the international healthcare market. In recent years, India has emerged as a hub for medical tourism and R&D activities (OECD, 2015). The government, as well as private healthcare firms, has recognized CRM practices as an important marketing tool to overcome their financial constraints and emphasize that concerted efforts in this domain are required to attract international customers and agencies (NSSO, 2015). The Indian healthcare sector is faced with challenges to deliver effective services under resource constraints and also to develop sustained relationships with the community they serve.

It is against this background that a case-based approach was undertaken for an in-depth understanding of the underlying dynamics of development and execution of CRM capabilities (Yin, 2008). The case study included a national healthcare firm. The detail of the case is depicted in Table I. Over the last few years, this firm has observed significant efforts of CRM campaigns and hence was chosen a representative case (Eisenhardt, 1989).

Hospital capacity		Respondents
Number of beds	1,985	Chief Executive Officer (A)
Average occupancy rate	94%	Medical Superintendent (B)
		Dean (C)
Annual registration	5,10,000	Chief Finance Officer (D)
Annual discharge	65,450	Nursing superintendent (E)
No. of employees	2,250	Administrative Officer (F)
Partnerships	WHO, UNICEF	HOD Medicine (G)
Customer satisfaction	81%	HOD Surgery (H)
Community centers	8	HOD Gynecology (I)
		Technician (J, 1–4), Nurses (K, 1–5), Support staff (L, 1–8)

Table I.
Overview of the case

3.2 Study I: data collection and analysis

The case study consisted of in-depth interviews with healthcare professionals from the case study of public healthcare organization and also included secondary document analysis. More specifically, we focused on extricating the dynamics of CRM capability within this case study organization. The respondents of the study represent the various operational groups in the organization across departments. The snowball sampling was used to identify the respondents of the study which continued till a point of saturation when it came to reaching the required information and where no further relevant information was extracted (Creswell, 2006). An interview schedule was developed from preliminary interviews and contacts in the organization. The semi-structured guide deliberately included questions concerning CRM capability. We probed the respondents to understand the utilization of resources and skills of the firm that facilitate various CRM campaigns. The interviews were conducted over eight weeks between September and October 2018. Typical interviews lasted from 45 min to an hour, with some interviews repeated and conducted more than once for clarity. The qualitative data collection was conducted over three stages. The first stage of the study focused on the overview of CRM practices. The second stage included questions to respondents about specific resources and capabilities of the firm in terms of carrying out CRM practices. Finally, the dimensions of the CRM capabilities identified at the second stage were validated by interviewing senior- and middle-level professionals in the organization, not previously interviewed (Table II).

We analyzed the interview proceedings using NVIVO 10 software (Welsh, 2002). Braun and Clarke (2006) argue that important themes can be observed within the descriptions of the informants when it comes to the phenomenon under study and provides a systematic and transparent mode of analyzing a qualitative data set. Themes were identified by analyzing the patterns of meaning within the data collected, and further, patterns were grouped to converge into particular themes. Thereafter, a thematic analysis was conducted to analyze the patterns of meaning that led to subjectively produce relevant patterns. Emergent themes were identified and demarcated within the raw data by the coders. The percentage agreement on the presence of themes was calculated using the formula proposed by Boyatzis (1998), i.e. [2×(No. of times both coders saw it present)]/[(No. of times the first coder saw it present)+(No. of times the second coder saw it present)].

The findings of the thematic analysis contributed to the following four dimensions of the CRM capability in the context of an emerging country healthcare sector: clinical branding capability, customer engagement capability (CEC), IT capability (ITC) and inter-organizational compatibility (IOC).

Level	Experience (in years)	No. of interviewees	No. of interviews	Focus area
Stage I				
Senior	20	4	6	Overview of CRM
Middle	10	5	8	
Stage II				
Senior	> 20	6	8	Dimensions of CRM
Middle	10–20	5	8	
Lower	5–10	10	16	
Stage III				
Senior	> 20	2	2	Validation
Middle	10–20	4	4	
Total		36	52	

Table II. Overview of qualitative data collection

Qualitative interview themes:

- Clinical branding capability (% agreement 69.50):

[…] When we look at the cause and the related sponsorships or donations by the companies, it influences the reputation of our clinicians and the overall branding of the firm as a clinical setting. How we deliver care and extend services to the community is, therefore, very important, once we need support for the particular cause. [A]

[…] organizations like WHO and UNICEF have a constant look at the quality and abilities of the medical units and departments. We, therefore, need to brand our clinical services to get a favorable reply from these organizations. [B]

[…] it is important to look at the activities that link with the community. Customer-linking activities through which our organization is differentiated in terms of clinical care and support given to the patients are important. [D]

[…] we need to communicate properly what is offered and the way it is offered. We focus on attracting patients by the offerings of our firm as superior service. [E]

- CEC (% agreement 72.40):

[…] we can attract any charitable organization only considering their views and feelings. By engaging them in the processes and activities, a fairness and transparency is created which is very important to get donations or funds for the cause. [C]

[…] I would say it is a part of our CSR strategy that we want to be known as a transparent organization. We engage our community to upgrade relationships and give a chance to voice their feelings and beliefs. [B]

[…] we insist on maintaining a two-way communication and ask for customer's input. It signifies a level of trust and affects the success of campaigns. [F]

[…] through ongoing dialogue, we work with each customer. The departments make coordinated efforts to engage them and build relationships. Such efforts to engage customers affect their attitude toward the CRM campaigns. [A]

- ITC (% agreement 70.05):

[…] cause-related marketing campaigns have gained momentum by the innovative use of technology. Communicating with partners, advertising, and the actual transactions ….all have become easier for implementing the marketing programs. [A]

We use the hospital web sites and social media as a major tool for cause-related marketing. Internet tools and many other computer-related technologies have facilitated in formulating, communicating and implementing our cause marketing policies. We can better aid in campaign programs that can affect the emotions of the supporting organization and community at large. [J1]

[…] we have adequate software and hardware tools as well as by IT professionals to execute marketing and advertising activities. An ongoing commitment by healthcare organizations to behave ethically is largely supported by IT professionals and their skills in disseminating the cause and related campaigns. [K2]

[…] many global agencies are have now started partnering with us to support AIDS and Blindness control programs. It is worth noting that this would not have possible without information technology. [L3]

- IOC (% agreement 61.66):

[…] I think, the most effective to way to motivate our charity partner is to make the campaign according to their objectives and goals. [C]

[…] we want to make sure that the charity partner is also aligned with the cause. For example, we seek donations from UNICEF for our neonatal unit and child welfare programs. [H]

[…] we find out a highly reputed and recognizable non-profit brand to associate with us. If the overall goals are aligned, it is easier to attract donations for the cause. [I]

[…] we look at the technical and cultural fit of the partnering organization. Work practices and values of the partner organization are important for us to strengthen our marketing campaigns and to raise funds from them. [F]

3.3 Study II: research framework and hypothesis development

3.3.1 Clinical branding capability. Clinical branding capability can be broadly defined as the ability of healthcare firms to mobilize organizational routines to perform branding activities (Cass and Ngo, 2011). It refers to the communication, pricing and distribution mechanism in the context of clinical services of the firm. CRM campaigns in healthcare involve a systematic communicative process that aims at the community to adopt certain healthcare messages and behaviors (Russo, 2016). Healthcare firms seek to build and nurture clinical branding capabilities in a way that it is appropriate to the value it has created (Quaratino and Mazzei, 2018). It could thus be argued that the process of care attracts and retains customers, which, in turn, increases the image of a healthcare organization and leads to a unique competitive advantage over other service providers and competitors. Therefore, firms essentially need to focus on the deployment of clinical branding capabilities that allows the campaigns to enter into and sustain a long-term, that includes a reciprocation of association with the community. It can thus be established from the above literature that clinical capabilities enrich value, thereby contributing to CRM capabilities, and hence we develop the following hypothesis:

H1a. Clinical branding capability (CLC) positively influences CRM capability.

3.3.2 Customer engagement capability. Studies have suggested that customer engagement reflects the co-creative and participative experiences of customers with the firm (Brodie *et al.*, 2011). Customers perceive "value in use" through the consumption of service and/or products that are adjacent to their social and self-perceptions, which, in turn, facilitate developing a participative relationship with them (Gronroos and Gummerus, 2014; Malik *et al.*, 2018). It has also been established that firms also essentially need to focus on customer's engagement to add an array of values to the service products. Evidence here suggests that customer engagement indicates their enduring involvement toward the firm activities, by spreading positivity through word-of-mouth and this contributes to a firm's performance (Christofi *et al.*, 2018). It can thus be argued that within a CRM campaign, customer's engagement with the different causes is supported by the firm which enhances its awareness and response to such campaigns. In this context, Christofi *et al.* (2018) argue that customer's engagement has a positive role in the effectiveness of CRM campaigns as well as influences positive behavior toward the CRM campaign. It could thus be posited that CEC of a firm triggers customers in their decision-making process of the CRM campaign and reduces customer skepticism. Furthermore, it can also be argued that within the healthcare sector, firms are focused on developing customer engagement capabilities to increase social responsiveness. We can thus hypothesize that CEC occupies a prominent position in CRM campaigns and positively affects customer's emotion, as suggested in our next hypothesis:

H1b. CEC positively influences CRM capability.

3.3.3 IT capability. IT has been widely employed in healthcare campaigns and marketing communications (Jayachandran *et al.*, 2005). Like other sectors, IT is utilized as tools and

assets for modern healthcare firms (e.g. social-media tools, telecommunication tools, hospital websites and audio–visual equipment) and these are also utilized to run several in-house campaigns (Brandão *et al.*, 2013). Healthcare campaigns aim at initiating and sustaining changes in knowledge, beliefs and attitude of the community about positive health behavior. The RBV explains how firms create value by utilizing IT assets which, in turn, impact on marketing strategies. With a positive infusion of technology, healthcare firms can provide tremendous support for effective and efficient campaigns thereby strengthening marketing capabilities (Brandão *et al.*, 2013; Tan and Sousa, 2015). Successful and rightful ITC can equip healthcare firms with the capability to record, analyze and disseminate the required information and health message in ways that ensure that adequate attention is being paid to campaign activities. Research focusing on IT capabilities in emerging economy context found that the use technology-based marketing campaigns (e.g. social-media tools, internet advertising and smartphone-based communications) are positively related with emotions and attitude of its customers (Ostrom *et al.*, 2015). Based on the above arguments, we can posit that IT capabilities of healthcare organizations facilitate marketing campaigns, consumption, increase interaction quality and influence relationships with customers, as is represented through our following hypothesis:

H1c. ITC positively influences CRM capability.

3.3.4 Inter-organizational compatibility. IOC between business partners indicates the sharing of common experience, values, principles and business strategies (Rajaguru and Jekanyika, 2013). The essence of CRM campaigns lies in partnering with non-profit organizations and/or government body and/or international agencies. For example, healthcare firms seek and formulate deliberate strategic relationships with pharmaceutical companies, NGOs, Society for AIDS control, WHO, etc. Such compatibility with partner organizations becomes key and is therefore very important to enhance brand credibility and brand attitude. Capability theory suggests that IOC arises as a strategic asset that enables partnering activities and continual adaptation of a firm's objectives (Christofi *et al.*, 2013). Therefore, firms seeking sponsorships need to develop capabilities to align with suitable and relevant partner organizations and hence need to achieve a state of compatibility (Ngai *et al.*, 2010). We thus posit that partnering organizations with similar objectives and cultures can easily develop successful partnership and inter-organizational integration and hence CRM capabilities are therefore affected by the degree of compatibility with partner organizations. These arguments lead to our next hypothesis:

H1d. IOC positively influences CRM capability.

3.4 Relationship between CRM capability and service innovation

CRM practices of a firm can create value through improvement in services linked with social or environmental issues (e.g. Christofi, Leonidou, Vrontis, Kitchen and Papasolomou, 2015; Christofi, Leonidou and Vrontis, 2015). Research further provides evidence that CRM increases the brand-cause fit which facilitates introduction of new services to the target market and their likeness (e.g. Samu and Wymer, 2009; Christofi *et al.*, 2014). Wagner (2010) suggests that CRM capability increases the brand reputation and authenticity with customers that then leads to greater market value through new services introduced. Similarly Tan and Sousa's (2015) study explores how CRM capability can be seen as a positive source of innovation linked to social issues. These arguments thus lead us to posit that an attempt to possess CRM capabilities identifies the needs of the market segments and

provides better service products to fulfill its needs. Furthermore, it can also be argued that CRM capability of a firm helps in establishing a direct link with customers to understand their preferences, facilitate redesign the services and deliver new or improved services. Thus, it is hypothesized that:

H2. CRM capability positively influences service innovation.

3.5 Mediating role of service flexibility

CRM capabilities improve the responsiveness of the firm and provide greater opportunities for customization in operations (Christofi *et al.*, 2018). It can also be argued that CRM practices of a firm increase the responsiveness toward customers and this affects the adaptation of their heterogeneous preferences. Thus, CRM allows to exhibit flexibility and become customer centric. The framework proposed by Christofi *et al.* (2013) indicates that CRM practices of the firm adapt to market changes and customer needs, thus increasing the flexibility of the said firm. Furthermore, CRM capability allows a firm to customize its services and adapt to the heterogeneous preferences (e.g. cause proximity, cause type and donation in kind) of customers (Christofi *et al.*, 2018). Additionally, SF creates a basis that supports the promises made in terms of improvements in services. It concerns the individual demand and response awareness to the customers, thus indicating the ability to identify new forms of value. SF includes rapid modification of service capacity and the introduction of new services at a greater speed (Lin *et al.*, 2015). SF allows the organization to learn about customer preferences, analyses of customer insights and increase in the degree of customization when it comes to redesigning of services. Therefore, service innovation becomes most effective when combined with increased responsiveness and greater flexibility. Hence, we hypothesize that:

H3. SF mediates the influence of CRM capability on service innovation.

3.6 Moderating role of service climate

There is a strong contention that service climate strengthens the ability that leads to a probable action of flexible disposition. A significant number of studies have discussed that mere possession of capabilities does not signify a flexible disposition (Teece, 2010; Morgan *et al.*, 2014; Brozovic *et al.*, 2016). On the contrary, it is the service climate of the firm that plays an essential role in structuring the resource portfolio and building capabilities that, in turn, exhibit flexibility (Teece, 2010; Gronroos and Gummerus, 2014). Mechinda and Patterson (2011) emphasize that service climate influences employee's perception of practices and procedures that are expected when it comes to the adaptation to change customer preferences.

Additionally, firms that build service climate, further promotes creativity (Christofi, Leonidou, Vrontis, Kitchen and Papasolomou, 2015; Christofi, Leonidou and Vrontis, 2015). Service climate also influences risk-taking behavior and provides psychological safety (Hoang *et al.*, 2018). As such, service climate becomes a psychological mechanism through which the development of new services is managed within a firm. Scholars (e.g. Drach-Zahavy and Somech, 2013; Morgan *et al.*, 2014) also assert that service climate makes employees more adaptable who, in turn, propose new ideas, facilitate redesigning of services and develop new service concepts to enhance innovation. Studies also reveal how service culture of the firm facilitates work groups exploring the problems in the delivery system that then calls for a change in working methods and improvement on service quality to add value (Kindström *et al.*, 2013; Barnes and Collier, 2013; Drach-Zahavy and Somech, 2013). A study by Morgan *et al.* (2014) highlighted that a firm that strives for a positive service climate attempts to differentiate itself through SF and is

better prepared for the new service concepts. We thus formulate the following hypotheses based on the above discussion:

H4. Service climate moderates the relationship between CRM capability and SF.

H5. Service climate moderates the relationship between SF and service innovation.

Based on above formulation of variables and its relationships as hypotheses, we predict the following model (Figure 1).

3.7 Data collection

To test the hypothesized model, data were collected using a survey administered to healthcare professionals. A pretest of the questionnaire was administered to ten senior healthcare professionals to get their valuable feedback before we finalized the survey. Random sampling was used for the final survey and was administered to 450 employees, with a proper briefing of questionnaire items. Participants for the study included doctors, nursing staff, para-medical staff and the administrative staff from the Top 10 national-level healthcare firms in India. A total of 290 employees completed the survey, resulting in a response rate of 64.44 percent.

3.8 Analyses

3.8.1 Controlling for common method variance (CMV). CMV was analyzed following the recommendations of Podsakoff *et al.* (2003). Furthermore, to reduce the likelihood of CMV, the respondents were assured of anonymity and confidentiality. A *post hoc* analysis (Harman's single factor) indicates only 20.3 percent of the variance for the first factor. The marker-variable approach was used for CMV validity (Malhotra *et al.*, 2006) which indicates non-significant (less than 0.05) difference between the CMV-adjusted and the original correlations for the constructs under study. The evidence here thus suggests that there is no threat when it comes to the CMV analyses, and therefore the predictions are not distorted.

3.8.2 Measures. The authors adopted multi-item measures from the extant literature and have modified the same to suit the context of the study and ensure face validity. We have further provided explanations on scales to ensure clarity and accuracy. The five-point Likert-scale (1 = strongly disagree to 5 = strongly agree) was used for rating. The details on measurement scale and literature support are depicted in Table III.

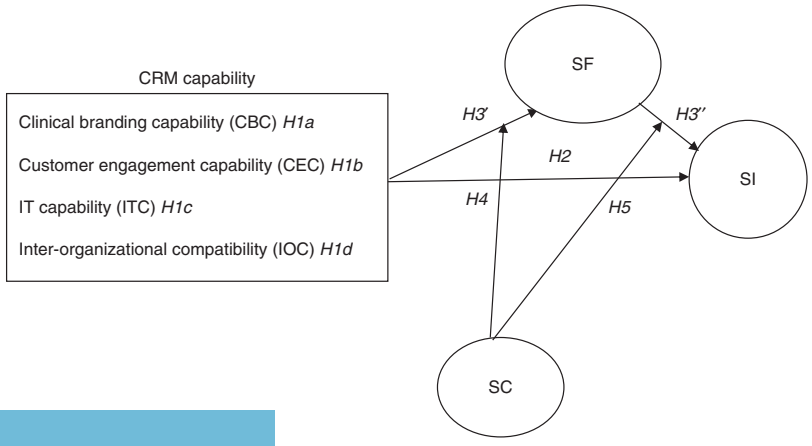

Figure 1.
Summary of hypotheses and conceptual model

Demographic variables	Frequency	%
Gender		
Male	160	55.17
Female	130	44.82
Current role		
Doctor	110	37.93
Nurse	85	29.31
Para-medical staff	56	19.31
IT staff	12	4.13
Others	27	9.31
Education		
Post graduate	150	51.72
Graduate	60	20.68
Others	80	27.58
Experience (in years)		
< 5	40	13.79
5–10	65	22.41
10–15	78	26.89
15–20	22	07.58
> 20	85	29.31

Note: $n = 290$

Table III. Respondent demographics

3.9 Results

Structural equation modeling (SEM) with partial least square (PLS) was used to test the hypotheses. The focus of the study was to predict the multiple causal relationships between one or more independent variables and one or more dependent variables. The scores of the latent variables were used in further analysis. Therefore, PLS–SEM was appropriate for the study (Hair *et al.*, 2016). Smart PLS (v.3 2.6) software was used to conduct PLS analysis (Ringle *et al.*, 2017).

3.9.1 Assessment of the measurement model. The measurement model was assessed using indicator reliability, internal consistency (composite reliability (CR)), convergent validity and discriminant validity. Outer loadings of all the constructs were statistically significant, Cronbach's (1951) α was significant ($\alpha > 0.70$) and the CR values were above the recommended values of 0.7 (Table IV). The convergent validity of the constructs, except CRM capability, was established as the average variance extracted (AVE) values were above the recommended value of 0.5 (Hair *et al.*, 2016). The most probable reason for this when the second-order latent variable is loaded by repeated indicator approach (Ringle *et al.*, 2017), it resists convergence into a single factor because it is a multidimensional construct. Five items of the scale (CBC4, CEC3, IOC3, SF4 and SI3) were dropped due to improper loadings. The discriminant validity was also established. First, the square root of AVE was greater than its highest correlation with any other construct (Fornell and Larcker, 1981). Second, the outer loadings of each construct were greater than its cross-loadings with other constructs (Hair *et al.*, 2016) (Tables V and VI).

3.9.2 Assessment of the structural model. The structural model was estimated using the bootstrapping procedure with 5,000 resamples (Hair *et al.*, 2016). The multicollinearity for the predictors of each construct was checked using VIF values, which were lower than 5 as recommended by Hair *et al.* (2016). The structural model explains 39.2 percent variance in SF and 32.45 percent in SI. The predictive relevance of exogenous variables was obtained by performing blindfolding (omission distance = 7). Results demonstrate positive Q^2 SF ($Q^2 = 0.096$) and SI ($Q^2 = 0.139$), therefore indicate a satisfactory predictive relevance. To assess the overall model fit the recommendations of Henseler *et al.* (2014) were followed

Measurement items	*M* (SD)
Clinical branding capability (CBC) (Cass and Ngo, 2011) α = 0.788	
We invest adequate resources in improvements in the clinical brand to provide better value to the patients (CBC1)	3.9 (0.86)
We focus on creating a positive brand experience for our stake holders (CBC2)	3.79 (0.87)
We design our marketing activities to encourage the community to directly use our brand (CLC3)	4.12 (0.78)
We ensure that within our business we are aware of all of the marketing activities that involve the brand (CBC4)	3.99 (0.76)
We develop marketing programs that send consistent messages about our brand to our stake holders (CBC5)	4.06 (0.79)
Customer engagement capability (CEC) (Brodie et al., 2011) α = 0.712	
We provide support to develop and nurture relationships with customers (CEC1)	3.81 (0.79)
We develop emotional connections with the customers (CEC2)	3.79 (0.85)
We have the ability to connect with customers in a meaningful way (CEC3)	3.81 (0.84)
We repeatedly interact with customers to leave a positive impression (CEC4)	3.66 (0.91)
IT capability (ITC) (Jayachandran et al., 2005) α = 0.766	
We use health information technology for customer-related services (ITC1)	3.84 (0.91)
Our computer technology can provide customized services (ITC2)	3.69 (0.87)
We continuously monitor and maintain customer-related information (ITC3)	3.71 (0.87)
Our organization has expertise to utilize technology in building customer relationships (ITC4)	3.59 (0.94)
Inter-organizational compatibility (IOC) (Rajaguru and Jekanyika, 2013) α = 0.822	
Our firm's procedure is compatible with the approaches of partner organizations	3.85 (0.80)
The goals and objective of our firm are compatible with partner firms	3.80 (0.81)
The values and social norms prevalent between our firm and partners are congruent	3.68 (0.82)
The partner firms deliver services in a synergistic way	3.66 (0.86)
Service flexibility (SF) (Lin et al., 2015) α = 0.813	
We are responsive to the need of customers (SF1)	3.89 (0.96)
We can quickly respond to changing requirements and preferences (SF2)	3.33 (0.95)
We have the ability to understand the problem from customer's viewpoint (SF3)	3.27 (0.95)
We quickly try to coordinate across functional boundaries to respond to different situations (SF4)	3.30 (0.98)
Service innovation (SI) (Kindström et al., 2013) α = 0.716	
We provide innovative ideas and solutions to the customers for enhanced satisfaction (SI1)	3.23 (1.02)
We provide our customers with services that offer unique benefits (SI2)	3.31 (0.99)
We seek novel ways to deal with customer problems (SI3)	3.11 (1.04)
We provide innovative services for follow up and after-service supports (SI4)	3.48 (0.88)
We solve customer problems in innovative ways (SI5)	3.46 (0.90)
Service climate (SC) (Morgan et al., 2014) α = 0.851	
The job knowledge and skills of employee to deliver superior customer service are outstanding	4.12 (0.78)
We provide strong support of efforts to provide superior customer service	3.99 (0.76)
The overall climate for service in organization is excellent	4.06 (0.79)
Employees receive excellent rewards for superior customer services	3.89 (0.93)

Table IV.
Measurement scale

by using standardized root mean square residuals (SRMR) as an index for model validation. The PLS results reveal an SRMR value of 0.080 which is less than the threshold of 0.10 (Hair *et al.*, 2016).

3.9.2.1 CRM capability as a higher-order factor. The study first intended to examine the multi-dimensionality of CRM capability. The resultant first-order factors are

	Outer loadings	*t*-value	VIF	CR	AVE
Clinical branding capability (CBC)				0.801	0.503
CBC1	0.759	20.916	1.358		
CBC2	0.757	21.526	1.264		
CLC3	0.66	13.913	1.214		
CBC4 (dropped)					
CBC5	0.645	12.799	1.242		
Customer engagement capability (CEC)				0.775	0.535
CEC1	0.741	22.137	1.197		
CEC2	0.76	27.821	1.184		
CEC3 (dropped)					
CEC4	0.691	19.44	1.128		
IT capability (ITC)				0.824	0.54
ITC1	0.771	28.696	1.42		
ITC2	0.751	30.114	1.384		
ITC3	0.69	20.741	1.282		
ITC4	0.723	24.589	1.362		
Inter-organizational compatibility (IOC)				0.782	0.545
IOC1	0.746	24.004	1.205		
IOC2	0.776	30.91	1.22		
IOC3 (dropped)					
IOC4	0.685	16.155	1.137		
Service flexibility				0.815	0.525
SF1	0.758	25.175	1.352		
SF2	0.664	14.187	1.282		
SF3	0.703	19.326	1.315		
SF4 (dropped)					
SF5	0.765	25.302	1.356		
Service innovation				0.831	0.552
SI1	0.817	27.65	2.784		
SI2	0.783	30.753	1.452		
SI3 (dropped)					
SI4	0.629	13.429	1.158		
SI5	0.731	18.111	2.446		
Service climate				0.801	0.505
SC1	0.609	5.532	1.144		
SC2	0.6	5.506	1.101		
SC3	0.79	7.322	2.646		
SC4	0.756	6.206	2.506		

Table V.
Reliability and validity indices

moderately correlated. Therefore, in this study, CRM capability is conceptualized as a higher-order factor with the four sub-dimensions as clinical branding capability (*H1a*), CEC (*H1b*), ITC (*H1c*) and IOC (*H1d*). The clinical branding capability ($\beta = 0.251$, $t = 7.356$, $p = 0.000$), CEC ($\beta = 0.313$, $t = 18.494$, $p = 0.000$), ITC ($\beta = 0.441$, $t = 23.952$, $p = 0.000$) and IOC ($\beta = 0.306$, $t = 14.652$, $p = 0.000$) positively influences CRM capability. Thus, PLS analysis results indicate that *H1a–H1d* are supported.

3.9.2.2 Mediation analysis. We followed Baron and Kenny's (1986) logic for testing the mediated mechanism of SF. The direct impact of CRM capability and service innovation is significant ($\beta = 0.175$, $t = 3.422$, $p < 0.05$). Thus, *H2* is supported. When the mediating variable is introduced, this relationship becomes insignificant ($\beta = 0.045$, $t = 0.911$, $p = 0.362$). However, the impact of CRM capability on SF ($\beta = 0.194$, $t = 3.899$, $p = 0.000$) and the relationship between SF and service innovation are significant ($\beta = 0.496$, $t = 11.586$, $p = 0.000$).

Moreover, the indirect relationship between CRM capability and service innovation is significant ($\beta = 0.096$, $t = 3.709$, $p = 0.000$). The bootstrapping results of indirect effects

S. No.		1	2	3	4	5	6	7	8
1	CBC	*0.709*							
2	CRM capability	0.531	*HOF*[a]						
3	IOC	0.551	0.776	*0.738*					
4	ITC	0.501	0.862	0.563	*0.735*				
5	CEC	0.478	0.795	0.551	0.552	*0.732*			
6	SC	0.749	0.334	0.072	0.173	0.151	*0.71*		
7	SF	−0.041	0.121	0.107	0.098	0.171	−0.095	*0.725*	
8	SI	0.125	0.175	0.151	0.081	0.193	0.15	0.492	*0.743*

Table VI. Tests for discriminant validity

Notes: [a]CRM capability is a higher-order factor (HOF), hence not considered in correlation analysis (Hair *et al.*, 2016). Diagonal elements are square root of average variance explained (AVE)

also reveal that clinical branding capability, CEC, ITC and IOC positively influence SF and service innovation through CRM capability. These results confirm the full mediation of SF (Table VII).

3.9.2.3 Moderation analysis. Furthermore, we created two moderating effects of service culture between the relationships, first, between CRM capability and SF (Moderating Effect 1, *H4*), and the other between SF and service innovation (Moderating Effect 2, *H5*). To examine the moderating effects, the product indicator approach was utilized (Hair *et al.*, 2016). The bootstrapping results (Figures 2–4 and Table VI) indicate that the Moderating Effect 1 is significant ($\beta = 0.241$, $t = 4.981$, $p = 0.000$). However, the Moderating Effect 2 is not significant ($\beta = 0.115$, $t = 0.781$, $p = 0.435$) (Table VIII).

4. Discussion

This study attempts to investigate the constituents of CRM capability in an emerging country healthcare context. We posit that CRM capabilities reflect a firm's potential to carry out social responsibilities. We further argued that the dimensions of CRM capabilities facilitate formulating marketing strategies and campaigns that support a designated cause. More specifically, this study explored and identified four specific dimensions of CRM capabilities as clinical branding capability, CEC, ITC and IOC. The key dimensions were identified and operationalized to explain how healthcare firms develop such an important marketing capability that connects the firm with a range of social issues and causes. Findings from our study confirm that CRM capability as a higher-order factor positively influences service innovation. However, when the mediating variable of SF is introduced, the strength of the relationship is suppressed and becomes insignificant. On the other hand, findings from our study suggest that all

Direct impact	Standardized direct effect	SE	*t*-value	*p*-value	Hypothesis testing
CBC → CRM capability	0.251	0.034	7.356	0.000	Accepted
CEC → CRM capability	0.313	0.017	18.494	0.000	Accepted
ITC → CRM capability	0.441	0.019	23.408	0.000	Accepted
IOC → CRM capability	0.306	0.021	14.652	0.069	Accepted
CRM capability → SF	0.194	0.05	3.899	0.000	Accepted
SF → SI	0.496	0.043	11.586	0.000	Accepted
CRM capability → SI	0.045	0.049	0.911	0.355	Not accepted[a]
Moderating Effect 1 → SF	0.241	0.044	4.981	0.000	Accepted
Moderating Effect 2 → SI	0.115	0.017	0.787	0.435	Not accepted

Table VII. Testing for direct impact

Note: [a]When mediating variable is introduced CRM→SI direct path is insignificant

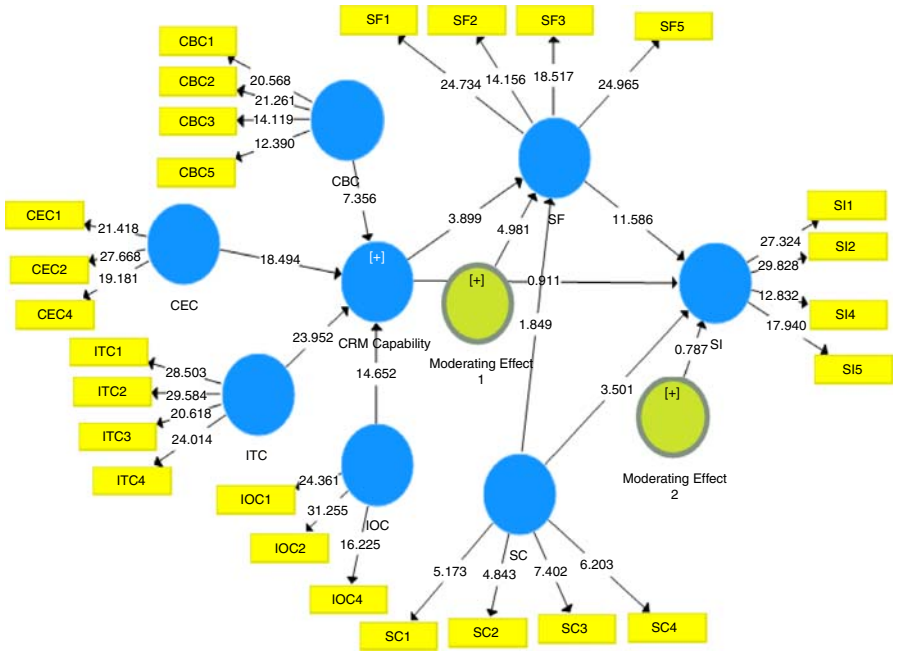

Figure 2.
Bootstrapping results (empirical assessment using PLS–SEM)

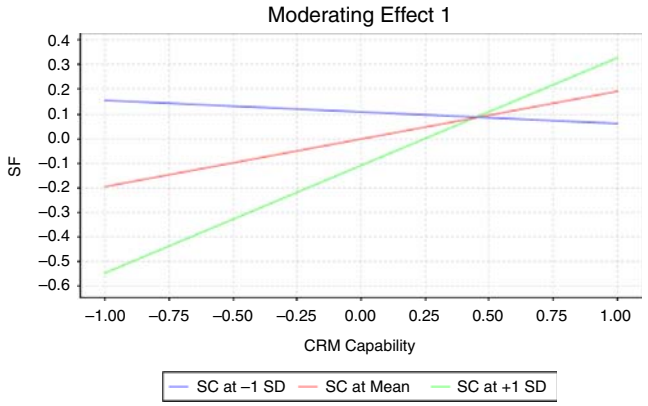

Figure 3.
Moderation of service climate on CRM capability–service flexibility

indirect relationships are significant which confirms the full mediation of SF. Moreover, findings from our study show that service climate moderates one of the two hypothesized relationships. It reaffirms that service climate of the firm plays an important role in strengthening the relationship between CRM capability and SF.

4.1 Implications for theory

Based on our research findings, there are several implications for theory. First, our study is a response to the recent call by scholars (e.g. Christofi, Leonidou, Vrontis, Kitchen and Papasolomou, 2015; Christofi, Leonidou and Vrontis, 2015; Russo, 2016; Duarte and Silva, 2018) to identify the constituents of CRM capabilities in the context of healthcare and

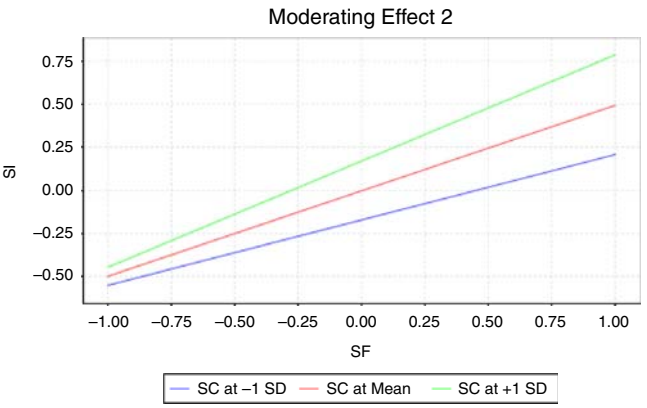

Figure 4.
Moderation of service climate on service flexibility–service innovation

	β values	SD	t-values	Significance
CBC → SF	0.049	0.014	3.426	Significant
CBC → SI	0.036	0.015	2.454	Significant
CEC → SF	0.061	0.016	3.761	Significant
CEC → SI	0.044	0.017	2.634	Significant
CRM capability → SI	0.096	0.026	3.709	Significant
IOC → SF	0.06	0.015	3.892	Significant
IOC → SI	0.043	0.016	2.636	Significant
ITC → SF	0.086	0.022	3.908	Significant
ITC → SI	0.062	0.023	2.726	Significant

Table VIII.
Testing for indirect impact

explain how marketing resources (Jayachandran *et al.*, 2005) aid in greater overall performance.

Second, the study also contributes to the extant literature on RBV (Barney, 1991) by identifying specific dimensions of CRM capability within an emerging country healthcare context. The study contributes to relevant identified underlying dimensions that are operationalized for developing CRM capabilities of the firm. Prior studies have investigated the relationship of corporate social responsibility and innovation (Brandão *et al.*, 2013; Christofi, Leonidou, Vrontis, Kitchen and Papasolomou, 2015; Christofi, Leonidou and Vrontis, 2015). However, a dearth of information exists on CRM aspects and innovation. Scholars have also underlined the bi-directionality of this relationship (Tsai, 2009; Wagner, 2010), even though the linkage from CRM to innovation is scant. Our study establishes a linkage between CRM capability and service innovation.

Third, several authors have indicated that CRM practices of the firm increase responsiveness and adaptability and seek to create innovative services (Demetriou *et al.*, 2009; Roy, 2010). Our investigation contributes by providing evidence of how CRM capability in healthcare firms influences service innovation reveal a mediating mechanism of SF and argues that SF is a missing link between CRM capability and service innovation.

Furthermore, fourth, service culture of the firm describes the flexible disposition and illustrates how the firm operationalize culture to gain a competitive advantage by developing new services (Gronroos and Gummerus, 2014; Morgan *et al.*, 2014). Our study also contributes here by providing empirical evidence that in an emerging market context,

mere possession of valuable resources does not affect the innovative services. Specifically, we investigate the moderating role of service climate in influencing SF and service innovation. Thus, our study extends the established framework (e.g. Wagner, 2010; Morgan *et al.*, 2014; Christofi, Leonidou, Vrontis, Kitchen and Papasolomou, 2015; Christofi, Leonidou and Vrontis, 2015; Skålén *et al.*, 2015) and develops an integrative approach to explore service innovation as well as provides theoretical significance by extending the perspectives on service climate.

Additionally, fifth, findings from our study are also consistent with previous studies (e.g. Zhang and Chen, 2011), and support the argument that organizations utilize valuable resources to develop flexible capabilities. Our study also extends the dynamic capability perspectives (Tan and Sousa, 2015) explaining the role of CRM capabilities in shaping the concept of flexibility as a dynamic capability and improving customer-centric service innovation. The study also supports prior studies on flexibility and performance outcomes (Christofi *et al.*, 2013; Lin *et al.*, 2015) by examining the association between SF and service innovation, leading to value creation for customers (Malik *et al.*, 2018).

4.2 Implications for practice

Service innovation is a central strategy pursued by healthcare firms for creating experiential value and sustainability. We argue that the dynamics of CRM capability makes the firm socially accountable, develops coordination in firm activities and facilitates a state wherein the firm continues to remain competitive in the global market. CRM capabilities link the firm with social or environmental causes. Thus, CRM capabilities drive innovation in services by maximizing effectiveness and efficiency of different services the firm provides. Hence, CRM capabilities make the firms to become market-oriented (Cadogan *et al.*, 2009; Roy, 2010) and that, in turn, facilitates innovative services. Therefore, the development of community-oriented CRM capabilities essentially focuses on marketing capabilities (Zhang and Chen, 2011).

Our proposed framework is conceived as a standardized tool to design and implement CRM practices successfully. It provides marketing managers with a systematic and structured way as it minimizes the risk of failure when conducting a CRM campaign. Results from our study suggests that healthcare firms need to develop professional skills and knowledge for designing and implementing CRM campaigns, delivering health messages effectively and managing long-term relationships with the community.

Moreover, by assessing the current service culture of the firm, the proposed CRM framework may also facilitate scrutinizing a firm's practices to increase its responsiveness and offer customer value propositions. As such, any identified maladies when it comes to SF or degree of customization can be improved, and services can be redesigned for customer's value creation.

Another major finding of potential interest to healthcare practitioners and policymakers is that successful service innovation is achieved not only by the resources, but also by a capability to develop a superior relationship with customers. Furthermore, management should also pay attention to improving the clinical quality, providing technology-based services and brand-cause fit for achieving a state of compatibility with partner organizations.

Relevant CRM capabilities will further promote a sustainable healthcare model, especially given scarce financial resources in the sector. CRM capabilities make the firm more accountable toward the healthcare needs of the society by improving its social connectivity. From the customer's perspective, CRM capabilities help creating a positive perception toward the cause and by being transparent toward, for example, the donation process of the firm. Thus, a positive attitude is created toward the cause which improves the level of trust in healthcare firms, which, in turn, is envisaged to reduce customer skepticism

to the cause and provoke positive word-of-mouth (Duarte and Silva, 2018). When such a scenario is created, patients may extend their support to the cause and become corporate donors (e.g. HIV/AIDS, cancer, hemophilia or cardiac diseases).

This paper also provides several implications for international business and marketing research. Findings from this study provide a link between CRM capability and service innovation, wherein innovativeness of the firm provides a reason to differentiate itself from others (competitors) by demonstrating its sustainability behaviors. Furthermore, CRM practices of the firm communicate their social connectivity and philanthropy to attract both local and international customers by aligning with the various social and environmental issues. Healthcare firms portray themselves as being socially responsible and link themselves to the standardization and adaptations of international marketing strategies. The firm also builds its brand image through CRM capabilities to remain competitive in the global market and to attract customers across the world. More importantly, CRM capabilities provide a new path to enter into the global market by communicating their business strategies and adapting to heterogeneous preferences of international customers.

5. Limitations and future research work

Although findings of the current study are of substantial interest, we recognize a few limitations that we spell out here. First, our study indicated that CRM capability as a higher-order factor is significantly associated with service innovation and the relationship is mediated by SF. It could be argued that there may be a limit to the benefits of CRM capabilities on service innovation. It could also be argued that although our sample size ($n = 290$) is adequate, the cross-sectional data may not be appropriate to identify those effects. More research is therefore required to compare and identify the maximum value of the different organizational capabilities under the environmental dynamism. A solution here could be that data may be collected at different periods to capture the market forces that affect service innovation.

Second, we recognize that our study enriches and develops the RBV of the firm by revealing that the possession of clinical branding capability, CEC, ITC and IOC contributes to strong CRM capabilities. However, other dimensions of CRM capabilities may also be explored for better marketing campaigns. Our statistical analysis explains the mediating and moderating effects in the relationships of CRM capability and service innovation; it is possible here that in this context the respondents are unable to differentiate from other organizational capabilities essential for service innovation. As a plausible solution therefore, the respondents may be asked to identify different capabilities for service innovation and then asked to make the distinctions during the analysis.

Third, evidence suggests that the concept of CRM and customer profiles in healthcare is different than that of other businesses. However, we note that, the other complex parameters in healthcare domain remain unexplored which needs further investigation.

Fourth, the findings of the study are based on the Top 10 healthcare firms in India. Future studies should investigate the framework with more samples of organizations in a different context for better understanding.

Last, but on the least, we acknowledge the complexity of CRM campaigns in healthcare, alongside the influences of customer behavior, skepticism to the cause and attitude, which may independently or collectively affect these relationships. Hence, a future line of research could focus on exploring the difference in the perception and attitude of the individuals on different causes supported by the firm. Some interviews and focus group studies with customers may strengthen the findings and provide a better understanding of the framework so that increased service innovation is achieved especially in an emerging economy like India.

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Further reading

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Appendix. Interview schedule for Study 1

(1) How important is the cause-related marketing for the firm?

(2) What are the benefits that can be derived from CRM campaigns?

(3) What are the various types of donations or social causes that firm support?

(4) What are the challenges faced by the firm in executing CRM campaigns?

(5) Who are the major donor agencies or firms?

(6) What are the strategic processes that firm use to maximize the effectiveness of CRM campaigns?

(7) How do firm execute CRM campaigns?

(8) What are the specific resources that firm look for to carry out CRM campaigns?

(9) Does the firm need/utilize different resources for CRM campaigns as compared to the other service deliveries?

(10) How do firm meet local as well as international community need?

(11) How do CRM campaigns help developing relationships with the community?

(12) What capabilities are required by the firm to carry out CRM campaigns?

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