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The investigation of quality management practices on health and fitness industry

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ABSTRACT
This study examines the effects of quality management (QM) practices on the health and fitness industry. To do so, this study develops two competencies, such as relational competence (RC) and technical competence (TC). This study suggests that a resource-based view (RBV) and relational competence theory (RCT) can be applied to how QM practices are related to health and fitness industry. Throughout a thorough literature review, I argue that RC and TC positively mediate the relationship between QM practices and customers' behavioral intentions to use the health and fitness service. This study concludes with discussions and limitations.

KEYWORDS: Quality management, Resource-based view, Relational competence theory, Technical competence

INTRODUCTION
The health and fitness industry has been growing quickly and more emphasis is being placed on the quality of services (Tawse & Keogh, 1998; Papadimitriou & Karteroliotis, 2000). For example, it has been found that a number of companies produce high-quality services catering to more sophisticated market niches (Lloyd, 2005). In addition, because service and quality in health and fitness industry is the most critical success factors, the need for professionalization increases considerably (De Knop, Hoecke, & De Bosscher, 2004). Despite the importance of the quality of services in health and fitness industry, an examination of relationship between quality management (QM) practices and the health and fitness industry seems deficient (Hurley, 2004). Therefore, it is important to examine to what degree QM practices are associated with the health and fitness industry.

Fitness services operations usually require physical interaction between the provider and the customers. Therefore, fitness-services providers need to understand their customers’ need (Lagrosen & Lagrosen, 2007). For example, it has been suggested that service attributes, including the activities, physical properties, people, and intangible elements offered by an organization, have a positive impact on customer satisfaction, in fact influencing intention to repurchase (Ferrand, Robinson, & Valette-Florence, 2010). Notably, it has been suggested that service attributes can provide with benefits(McCarthy, 2004), such as retaining members and reducing costs associated with attracting new members, all of which are considered as part of QM practices. Although QM practices have been widely studied in other service fields, such as health care industry and airline industry, less research examines the relationship between a holistic QM practices and health and fitness industry. To fill the research gap, I intend to develop two competencies studied by Gronroos (1990), which play a crucial role in the health and fitness industry. For example, it has been suggested that qualities provided by the health and fitness industry are related to relational competence (RC) where staffs conduct themselves pleasantly towards customers by being friendly, empathetic, and being helpful to them so that RC can meet customer needs (Soita, 2012). In addition, as a service provider’s ability to offer a required service (Tawse et al., 1998), it has been suggested that technical competence (TC) is an important determinant of trust. This is because clients’ perception of their providers’ competence
could reflect clients’ confidence in service providers’ reliability and expertise (Eisingerich & Bell, 2007).

Two theories can explain the relationship between QM practices and health and fitness industry. One is resource-based view (RBV). RBV infers that the relative contribution of resources (e.g., physical, human, and organizational) may be different in industries that emphasize different technologies (Smart & Wolfe, 2003). Therefore, the influence of resource type and quality on performance may depend on whether an organization employs pooled, sequential, or reciprocal technology (Thompson, 1967). Particularly, the success of QM practices appears to rely more on leadership, open organization, and employee empowerment and that the key to the success lies in its intangible and behavioral features, such as top management support and employee involvement (Brah, Won, & Rao, 2000). In this sense, tangible resources, such as staff skills and abilities, and intangible resources, such as relationships, trust, and culture, could be considerably valuable in the health and fitness industry. Another is relational competency theory (RCT). L’Abate (2010:3) argues that RCT means “how effectively we deal with each other, with intimates and nonintimates in close/distant, committed/uncommitted, and short/prolonged relationships.” This definition indicates that within health and fitness industry “relational” means that there are prolonged bidirectional and interdependent exchanges between staffs and members.

In this study, I intend to answer the following questions. What is the relationship between QM practices and the health and fitness industry? What is the role of RC and TC which reflects the relationship between QM practices and the health and fitness industry? How do RBV and RCT reflect the relationship between QM practices and health and fitness industry? On the basis of a thorough literature review, four prepositions are suggested. This study can contribute to an integrated perspective between QM practices (operational perspective) and customers (marketing perspective) to the health and fitness industry. Implications for this research and limitations are discussed.

LITERATURE REVIEW

QM practices have been applied to various industries, such as food industry, airline industry, hotel industry, IT industry, and mainly manufacturing industry. However, the health and fitness industry has received little attention (Ennis & Harrington, 1999) and thus the attempt to apply QM practices to health and fitness industry seems insufficient. In order to expand QM practices to health and fitness industry, three aspects should be reviewed: an integrated definition of QM practices, characteristics of QM practices, and what has been studied on service industry. From these, I intend to uncover the relationship between QM practices and health and fitness industry.

QM practices have been defined as a philosophy or an approach to management made up of a set of mutually reinforcing principles, each of which is supported by a set of practices and techniques (Dean & Bowen, 1994). QM practices are all manners in which an organization meets the needs and expectations of its customers, personnel, financial stakeholders and society in general (Foley, 1994). However, the previous definitions seem ambiguous and unilateral so that they fail to provide a universal meaning of QM practices. For this reason, I adopts the recent definition of QM practices studied by Kaynak and Hartley (2005;2) who define QM practices as “a holistic management philosophy that strives for continuous improvement in all functions of an organization, and it can be achieved only if the quality concept is used in all organizational processes starting from the acquisition of resources to customer service after the sale.” Particularly, their definition focuses on continuous quality improvement and customer relationships, and it is consistent with the notion that customer focus and continual improvement were perceived as dominant QM practices (Arumugam, Ooi, & Fong, 2008).
It can be argued that QM practices improve business performance by improving operational performance, thus reducing costs, and through marketing by increasing sales and market share (Sousa & Voss, 2002). In addition, it has been suggested that top management commitment to QM practices is essential to creating an environment that empowers employees, encourages innovation (Howard & Foster, 1999; Latona & LaVan, 1993) and provides resources for training in quality improvement activities, such as quality tools and supplier relations (Sohal & Lu, 1998). Therefore, to uncover the effects of QM practices on the health and fitness industry, it is necessary to review characteristics of QM practices. There are eight common QM practices, such as management leadership, training, employee relations, quality data and reporting, supplier quality management, product/service design, process management, and customer relations.

Management leadership
It is the management task of maintaining and practicing a vision of the organization with respect to customer requirements, and with a full commitment to a total quality setting, leaders can organize and synergize people’s activities to achieve the common goal of the organization (Sadikoglu & Zehir, 2010).

Training
It involves technical skills, supervision skills, communication, teamwork, and customer relations, and workforce training in the techniques necessary for improving processes must be continuous if the improvement effort is to be sustained, for an ongoing training program will help employees discover innovative ways to improve the organization (Flynn, Schroeder, & Sakakibara, 1994; Choi, 1995).

Employee relations
It involves various organizational development techniques, such as employee participation in decisions, teamwork, and the use of effective communications to achieve organizational goals (Bell & Burnham, 1989; Daft, 1998; Ford & Fottler, 1995). For example, non-managerial employees can make significant contributions when they are empowered. Therefore, employee suggestions and participation are encouraged in a total quality setting (Sadikoglu et al., 2010).

Quality data and reporting
It involves using costs of poor quality, such as rework, warranty costs, and control charts, to identify quality problems and provides information on areas of possible improvement. Therefore, it is crucial for managers to make decisions based on analysis of relevant data and information to anticipate and respond to any organizational or external changes (Choi, 1995; Lockamy, 1998; Sadikoglu et al., 2010).

Customer relations
It is the most important part of production, mean producing and delivering products and services in order to fulfill customers’ present and future needs and expectations. Customer relations refer to exceeding customers’ expectations in order to ensure long-term organizational success and survival (Deming, 1986; Dean & Bowen, 1994).

Supply quality management
It enhances the performance of both suppliers and buyers, and this is especially true when quality and delivery are buyer priorities (Flynn et al., 1995; Shin, Collier, & Wilson, 2000). For example, buyers should select suppliers on the basis of quality, rather than solely on the basis of cost, build a long-term relationship marked by trust and loyalty (Deming, 1986; Walton, 1986), and work with them to improve their quality practices (Hackman & Wageman, 1995).

Product/service design
It means designing manufacturing products and/or designing quality into the products (Flynn et al., 1995; Handfield, Jayaram, & Ghosh, 1999), which reduce the number of parts per product and standardize the parts (Chase, Aquilano, & Jacobs, 2001). Therefore, it helps reduce process complexity (Ahire & Dreyfus, 2000; Flynn et al., 1995).

Process management
It emphasizes activities, as opposed to results, through a set of methodological and behavioral practices, and it includes preventive and proactive approach to QM practices to reduce variations and improve the quality of the product in the production stage (Kaynak, 2003; Flynn et al., 1995; Saraph, Benson, & Schroeder, 1989).

Quality management in service industry and the health and fitness industry

QM has its origin in manufacturing related organizations in the literature. In addition, it is widely believed that principles of QM are equally relevant to service organizations as QM uses facilities as inputs to satisfy customers’ needs (Brah, Wong, & Rao, 2000). For example, common management practices of service organizations with successful quality programs include quality process structure, customer involvement, continuous communication of the quality message, training managers to push down decision making, and integration of QM with performance evaluation (Warihay, 1993). In addition, elements of service quality include equipment, programs, facilities and ancillary services, and its role in client satisfaction and retention (Macintosh & Doherty, 2007). Furthermore, behavioral factors, such as management leadership, employee involvement, and open culture, can create competitive advantage in service industry (Terziovski & Samson, 1999). It can be concluded that just as a RBV represents value of intangible resources which in fact result in competitive advantages, so intangible and behavioral features in service industry can help provide with sustainable advantages.

Several scholars have studied service quality and offered different quality practices in the health and fitness industry. Ko and Pastore (2005) argue that service quality consists of four primary dimensions which are defined by several corresponding subdimensions: 1) Program quality (range of program, operating time, and information), 2) Interaction quality (client-employee interaction and inter-client interaction), 3) Outcome quality (physical change, valence, and sociability), and 4) Environment quality (ambient condition, design, and equipment). De Knop et al. (2004) develop seven checklists, such as strategic planning and marketing management, internal procedures and systems, external communication and image building, organizational culture and atmosphere, structure and characteristics of management, human resources management, and organization effectiveness, through which sport clubs can improve quality management. However, the previous studies seem to only provide a unilateral perspective in the health and fitness industry. For example, although Ko et al. (2005) well defines a conceptual model of service quality, it seems that they fail to offer a holistic QM perspective to the health and fitness industry. In addition, De Knop et al. (2004) offers insufficient evidence about how service attributes influence the health and fitness industry in order to improve consumer retention.

In sum, although there have been differentiated efforts by scholars (e.g., Ko & Pastore, 2005; De Knop et al., 2004) to examine the relationship between service quality and the health and fitness industry, it seems that they fail to provide with an integrating perspective between QM practices and the health and fitness industry. To do so, next I intend to develop two competencies, such as relational competence and technology competence.

Competence and customers’ behavioral intentions

It has been found that the health and fitness industry tends to have a significant interaction between staff members and customers. Empirical evidence supports that service quality has a direct influence on the behavioral intentions of customers (Parasuraman, Zeithaml, & Berry, 2004). What are behavioral intentions? Behavioral intentions are consequences of perceived value (Zeithaml, 1988). When customers perceive high level of quality from consumption experiences, they tend to express positive behavioral intentions. Researchers support an argument that there is a positive relationship between behavioral intentions and a service provider’s ability. For example, favorable behavioral intentions are positively associated with a
provider’s competence to get its customers to recommend them to other consumers, to remain loyal to them (i.e., repurchase from them), to spend more with the company, and to pay price premiums (Zeithaml, Berry, & Parasuraman, 1996).

In the health and fitness industry, two competences can increase customer perception of the service quality which leads to customers’ behavioral intentions to use the health and fitness industry. Competence means possession of the required skills and knowledge to perform the service (Parasuraman et al., 1985). It involves knowledge and skill of the contact personnel (e.g., intangible resources) and knowledge and skill of operational support personal (e.g., tangible resources). Relational competence (RC) involves “loving self and intimates, controlling self, being present and performing in various settings, adopting a creative-conductive style, volunteering, playing, and bestowing importance to self and intimates by keeping one’s priorities straight (L’Abate, 2010: 96).” RC is embedded in both people and the organization, and as such is difficult to copy or imitate; therefore, RC can reflect a RBV (Dyer & Singh, 1998). RC in the health and fitness service refers to the ability of the personnel to behave in a pleasant manner towards the customers by showing friendliness, empathy, attention to customer needs, courtesy, and helpfulness (Lagrosen et al., 2007). Therefore, it can be anticipated that the higher RC the health and fitness industry offers to customers, the higher customers’ behavioral intentions the health and fitness industry receives.

Another competence is technical competence (TC). It is knowledge of, and skill in the exercise of, practices required for successful accomplishment of a business. TC refers to a service provider’s ability to provide a required service (Tawse et al., 1998). Scholarly perspectives support an idea that there is a positive relationship between TC and behavioral intentions. For example, TC has a significant, positive effect on consumer trust, loyalty and repurchase intentions because TC is a vital determinant of trust, as clients’ perception of their providers’ competence is likely to influence clients’ confidence in service providers’ reliability and expertise (Eisingerich & Bell, 2007). In the health and fitness industry, facilities and equipment influences TC, and training offered to the personal includes their training in leading exercises (Lagrosen et al., 2007). From this, it can be anticipated that the higher TC the health and fitness industry offers to customers, the higher customers’ behavioral intentions the health and fitness industry receives.

In sum, it can be argued that RC and TC is positively related to customers’ behavioral intentions. Next, in order to examine the relationship between QM practices and health and fitness industry, I apply two competencies through which eight QM practices are related to the health and fitness industry. Figure 1 shows proposed research model of the relationship between QM practices and health and fitness industry.
THEORETICAL DEVELOPMENT/MODEL

Figure 1. Proposed research model of the relationship between QM practices and health and fitness industry

Upper four QM practices and customers’ behavioral intentions through relational competence

In health and fitness industry, it has been suggested that management leadership can refer to the common sense of leaders and their ability to motivate and encourage their employees, and it affects organizational climate, empowerment, and service design (Lagrosen et al., 2007). In addition, leadership could influence dynamic process in which one individual (employee) influences others (employees) to contribute to the achievement of the group task (Morden, 1997). Therefore, it is anticipated that managers can increase RC, which is positively associated with customers’ behavioral intentions to use the health and fitness industry. In this sense, it can be argued that management leadership is positively related to RC.

Customer relations can be applied to the climate of the fitness center, both to smooth and harmonious collaboration within the center among the employees in various parts of the centre and between employees and customers. In addition, supplier quality management could be applied to smooth collaboration between the company and its external partners (Lagrosen et al., 2007) and influence strong interdependence of supplier and customer (i.g., employee and customer). Therefore, it can be argued that two QM practices, such as customer relations and supplier quality management, are positively related to RC.

Employee relations can be applied to employees having the authority to adapt the services as required to the needs and wants of customers (Wisniewski, 2001). Particularly, since it is difficult for managers to control all activities in the service operations of a fitness club, it is crucial to have committed and empowered employees. Therefore, it can be argued that employee relations have a positive association with RC. Based on these observations, I propose the following propositions.

Proposition 1. Four QM practices, such as management leadership, customer relations, employee relations and supplier quality management, are positively associated with RC.

Proposition 2. RC positively mediates between these four QM practices and customers’ behavioral intentions to use health and fitness service.
Lower four QM practices and customers’ behavioral intentions through technical competence

Quality data and reporting can be applied to evaluation and the identification of issues that require improvement in health and fitness industry. For example, it has been suggested that changing the behavior of personnel is achieved through the training factor, and improvements to the facilities is achieved through the facilities factors (Lagrosen et al., 2007). Therefore, it can be argued that quality data and reporting is positively associated with TC.

Training mainly affects TC. This is because training can be applied to the training of the personnel, including their training in leading exercises, coaching customers, and providing treatments correctly (Lagrosen et al., 2007). Additionally, such training can induce employees to be more service minded in providing good service to customers. Therefore, it can be argued training is positively associated with TC.

Service design can be applied to the foundation of the firms’ TC. Service design is the responsibility of the leaders; therefore, it should be more systematized than it is at present (Gummesson, 1993). This is especially relevant to fitness companies because the continuous inclusion of new exercises and treatments is necessary to attract the interest of customers. Moreover, process management can also be applied to these new activities which are usually developed in collaboration with a valued resource network of partners, part-time instructors, and volunteers (Chelladurai & Chelladurai, 1999). Therefore, it can be argued that two practices, such as service design and process management, are positively associated with TC. Based on these observations, I propose the following prepositions.

Proposition 3. Four QM practices, such as quality data and reporting, training, service design and process management, are positively associated with TC.

Proposition 4. TC positively mediates the relationship between these four QM practices and customers’ behavioral intentions to use health and fitness service.

DISCUSSION AND CONCLUSIONS

Since the relationship between QM practices and service industries, such as traditional health care (Arcelay et al., 1999) and banking, have received an attention, QM practices should also equally be applied to the health and fitness industry. In addition, because quality of the services in health and fitness industry is the most important success factor, scholars need to offer an extra attention to the health and fitness industry by expanding QM practices.

This study has provided with a practical foundation to health and fitness industry by showing how QM practices are related to health and fitness industry throughout RC and TC. In detail, this study developed two competencies, such as RC and TC which mediate the relationship between QM practices and the health and fitness industry. In addition, this study has provided with an integrated perspective between operations (QM practices) and marketing (e.g., customers’ behavioral intentions). Furthermore, this study has offered solid theoretical background (e.g., RBV and RCT) which can connect QM practices with the health and fitness industry.

In addition to mediators, such as RC and TC, researchers should concern moderators, such as organizational culture. It might have an impact on the relationship between QM practices and health and fitness industry. For instance, values, beliefs and basic assumptions could help guide and coordinate member behaviors (MacIntosh & Doherty, 2009). Therefore, organizational culture may be an important factor of the service environment that influences client member attitudes and behaviors (Hatch & Schultz, 1997; Kowalczyk & Pawlish, 2002).

This study has, however, some limitations which need to be addressed in future study. It didn’t consider indirect relationship between each quality practice and two competencies. For
example, managerial leadership and training could not only influence RC but also TC. In addition, this study may not be convinced without having empirical investigation (e.g., how to measure customers’ behavioral intentions). Therefore, it is recommended that scholar need to address these limitations in future study.

More efforts on the relationship between QM practices and health and fitness industry need to be considered.

REFERENCES


