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EMPLOYEE ENGAGEMENT AND PATIENT EXPERIENCE AS PREDICTORS OF HOSPITAL REPUTATION: INTEGRATING HRM AND MARKETING IN SAUDI HEALTHCARE

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ABSTRACT

This paper draws on research findings related to human resource management (HRM) and marketing to examine the potential impacts of engagement and patient experience on hospital reputation in Saudi Arabia. An integrative literature review of peer-reviewed research on constructs of engagement, quality of care, patient experience, and reputation, together with Saudi policies and literature specific to the country's health sector was conducted. This was not a meta-analytic study but a theoretical one. Results: The review suggests that organisational resources, which are generally defined via HRM, correlate with engagement; engagement correlates with safety and quality of services measures; and relational and functional indicators of patient experience are credible markers of quality and trustworthiness of hospitals. Empathy, responsiveness, communication capability and cultural congruency are among significant factors identified by Saudi literature. There is a paucity of direct causal evidence in Saudi Arabia about correlations between the above three constructs. Conclusions: Based on the findings, a multilevel framework is suggested where patient experience mediates the effect of employee engagement on hospital reputation, and where the conditions are set by service culture and cultural-communication capability.

KEYWORDS: service quality, relational care, organisational advocacy, internal branding, health-sector transformation, value-based care, service climate, cultural congruence, communication capability, corporate image.

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1. INTRODUCTION

Transformation of Saudi Arabia's Health Sector aims for a more holistic, efficient, and people-oriented health sector, where it measures the satisfaction of its beneficiaries regarding their experience in hospitalization (Saudi Vision 2030, 2026). This particular policy direction ensures that the experience of a patient as part of the health care delivery becomes the main focus of the policy. However, at the same time, hospitals have become distinct due to the extent to which they engender trust and confidence in the minds of their patients, families, employees, regulators, and partners. This perception by stakeholders has been termed in this context hospital reputation – it refers to the perception of the hospital's trustworthiness, quality, and reputation in society.

The difficulty lies in the fact that workforce and market-related activities are usually operated independently of each other. The HRM department may take responsibility for monitoring staffing levels, training and development of staff, wellbeing and employee retention, whereas the marketing department may be responsible for customer satisfaction, referral intentions and brand perception. However, the patient's experience is largely co-created through interactions with employees and their ability to communicate and coordinate. If there are no sufficient resources, voice, motivation or skills within the hospital to deliver patient-centered care, reputation-related programs cannot make up for that deficiency.

The current study will apply the above interdepartmental argument to Saudi healthcare system. The objectives of the study are to (i) review the existing evidence about the links between engagement–quality and patient experience-quality; (ii) analyse the factors within Saudi Arabia context that could affect the generalizability of these links; and (iii) develop a model, where the link between employee engagement and hospital reputation is mediated by patient experience. The study will be conceptual and analytical and will not include a new patient or staff survey.

2. CONCEPTUAL BACKGROUND

2.1. Employee Engagement as an HRM-Enabled Resource

Employee engagement has been defined as a psychologically positive and enjoyable experience involving vigour, dedication, and absorption (Schaufeli et al., 2006). According to Kahn (1990), engagement occurs due to psychological significance, security, and availability. The Job Demands – Resources model further explained that employee engagement is more probable when employees possess the required resources for coping with demanding tasks at work, such as supportive supervision, autonomy, feedback, learning opportunities and adequate staffing (Bakker and Demerouti, 2007). In the case of healthcare organizations, especially hospitals, these resources are not only personal but also affect the capacity of employees to concentrate, empathize, speak out concerning risks and coordinate care between different professionals (Yadav et al., 2022; Kavyashree et al., 2023).

There is clear support for a positive association, albeit non-deterministic, between engagement and quality. In their meta-analysis of 11 studies, Janes et al. (2021) report a small but significant correlation between engagement and patient safety outcomes ($r = 0.22$; 95% confidence interval 0.07-0.36). Likewise, Scott et al. (2022) confirm that the direction of association is generally positive, despite variation in measurements and effect sizes among the studies considered. Organisational-level research reveals that, across 97 English National Health Service acute trusts, Wake and Green (2019) found that engagement predicted quality ratings. This provides a basis in evidence for why engagement might be regarded as a potentially significant organisational resource.

2.2. Patient Experience as an Experiential Quality Signal

Experience of care encompasses much more than just satisfaction. It includes observation and perception of care throughout the experiences with the hospital, which include dignity, attentiveness, information, involvement in decision-making, timeliness, physical comfort, coordination, and continuity. According to Doyle et al. (2013), relational experience is comprised of elements like empathy and respect, while functional experience includes timely and coordinated services. In their systematic review of 55 studies, they observed that most of the correlations between patient experience and safety/clinical effectiveness are positive. Therefore, experience should not be idealized as hospitality or marginalized as something unprofessional.

Empirical studies from Saudi Arabia show the importance of interpersonal signals and service process signals. In government hospitals in Southern Saudi Arabia, empathy was the highest predictor of service quality and patient satisfaction, followed by tangibility and responsiveness (Alghamdi, 2014). In

Qassim, in private hospitals, patients had better scores on all SERVQUAL dimensions and overall satisfaction compared to government hospitals; empathy and responsiveness were relatively lower dimensions in both settings (Alharbi, 2023). These studies have been done in the region and are cross-sectional studies.

2.3. Hospital Reputation as a Stakeholder-Level Outcome

The reputation of a corporation represents stakeholders' overall evaluation of how the organization creates value over time as compared with other alternatives (Fombrun et al., 2000). In the context of services, a customer-based corporate reputation consists of the following aspects: competence, customer orientation, reliability, social responsibility, and attractiveness (Walsh and Beatty, 2007). Applying the concept to hospitals, reputation refers to confidence in service and clinical quality, ethics, communication, patient orientation, and recommendation. It is based on personal experience, word of mouth, referral, network relations, signals of quality, and publicly available information.

This means that the concept of reputation comes after the experience of operation of the organization. The reputation of a hospital cannot be explained by only one patient experience, nor by communication performed by the organization. Patient experience is one of the most important ways how the hidden reality of an organization becomes clear for external stakeholders. This relationship needs to be investigated at the same level as reputation.

2.4. Saudi Service Culture and Communication Context

A general international approach warrants contextual caution within the context of Saudi Arabia's healthcare sector. As discussed by Alshammari et al. (2019), 20 studies have concluded that language, culture and religion could impact nurse-patient interactions, patient safety and satisfaction. Language, culture and religion could become critical when expatriate clinical staff interacts with Arabic-speaking patients. Job satisfaction in a study conducted in Saudi Arabia's health workforce was related to the quality of care, and stress management, workplace environment and patient satisfaction were important workplace factors (Halawani et al., 2021). Other important aspects include decentralization, digitization, changing role of public-private sectors and human resource challenges in the process of transforming the Saudi healthcare sector (Alasiri and Mohammed, 2022).

3. METHODS

This review employed the method of a structured, integrative-review in the development of a contextually-situated theoretical framework. This method was chosen because the research question falls within the domains of HRM, health services research, patient experience research, and marketing, and therefore the evidence is based on systematic reviews, organisational studies, surveys of hospitals, and policy documents. This review was theory-building, and not preregistered as a systematic review, nor did it use a risk-of-bias score for every document, or derive a pooled effect size.

Relevant English language literature published between 2006 and 2026, based on the themes "employee engagement," "work engagement," "hospital," "patient experience," "service quality," "reputation," "Saudi Arabia," and "healthcare," were searched for using the database(s). Priority was given to: (i) systematic reviews and/or meta-analysis; (ii) organisational/hospital-based peer-reviewed studies using measured variables; (iii) Saudi Arabian studies relating to the experience of either the workforce or patients; and (iv) Saudi Arabian governmental policy documents. Exclusion criteria involved non-scholarly commercial commentaries with no available methods sections, studies restricted to non-healthcare consumer services, and unsubstantiated claims made by authors.

The integration process involved three stages. The first stage entailed organising the findings according to HRM antecedents, employee engagement, patient experience, and reputation. The second stage involved identifying similarities between recurring mechanisms and context modifiers in different studies. Finally, the findings were summarised in the form of directional propositions, whereby an attempt was made to distinguish empirically observed relationships from those purely theoretical which require future investigation in Saudi Arabia.

4. RESULTS: THEMATIC SYNTHESIS AND PROPOSITIONS

Four interconnected themes were identified through the review of the literature. First, HRM resources are the organizational controllable inputs that are most likely related to the concept of engagement. Leadership support, sufficient staffing, participation, recognition, development and psychological safety can contribute to employees' ability and willingness to commit themselves to their job. Second, engagement is associated with behaviors and climates that patients may experience in

hospitals such as concern with safety, helpfulness, coordination and advocacy for patients' needs. While the evidence is heterogeneous and associative in nature, the consistent directionality allows treating the phenomenon as an antecedent of service delivery.

Third, the patient experience transforms everyday service delivery into the external quality signal. Communication, respect, empathy, responsiveness and reliability become the grounds for patients to assess the competences and trustworthiness of a hospital. Fourth, culture-specific communication, language, religion and culture-specific environment can affect how those signals are formed and perceived. For instance, the influence of a staff member's engagement on patients can be less noticeable if a staff member fails to communicate effectively in terms of patients' expectations, and a positive interaction becomes more relevant to hospitals' reputation if it fits the idea of dignity and respect for patients.

5. DISCUSSION

This model shifts the focus from hospital reputation to the output of service culture. This framework does not claim that HRM is all that matters when it comes to the reputation of the hospital or that a nice interaction can replace the safety of the treatment itself. Instead, this framework links the internal work environment to the aspect of quality that can be observed and communicated about by the patient. Such an approach is significant because the patient does not always see the full picture of technical processes; what she does see is the process of communication and coordination of efforts.

The theory also broadens the debate in moving beyond the simple one-sided process from the employees to the patients. Service culture may provide the setting where motivated employees can use their motivation to act on behalf of the patients; without the supportive culture, proper alignment of incentive systems and leaders' behavior, individual motivation will simply go to waste. In the Saudi Arabian hospitals, cultural and communication skills may play an important role not only in the implementation of the process but also in its interpretation.

5.1. Implications For Future Empirical Research

The appropriate methodology to measure the Saudi test is a multi-source and multilevel approach. Unit-level employees can answer the UWES-9 or any other equally validated Arabic version of engagement scale. Patients can measure their experiences in relations to functions after each episode of care using culturally adapted items. The reputation can be assessed separately by patients' and communities' perceptions, recommendation preferences and, if necessary, independently rated quality or review data. Translation, back-translation, cognitive interviews, and measurement of factor structure and invariance in measuring major employee groups and patients should be performed.

For minimizing the risk of common-method and reverse causality bias, time separation between measurement points is needed. Staff engagement may be assessed at Time 1, aggregated patient experience at the unit level – at Time 2 and reputation-related outcomes - at Time 3. All analysis should take into account clusters for unit and hospitals, clinical acuity, hospital ownership, region, hospital size, staffing mix and access to technology. A longitudinal multilevel structural equation model is more appropriate for this mediation than one cross-sectional questionnaire.

5.2. Implications For Practice and Policy

For those responsible in hospital leadership, integration starts with a common performance architecture. The HRM, quality, and patient experience groups could work together to determine if the same departments display signs of workload stress, disengagement, communication problems, and low experience ratings. The right thing to do would not be a separate reputation effort, but rather the targeted improvement of the work process and patient experience. Examples include scheduled huddle and shift turnover times, management coaching, recognition of patient-centred behaviour, interpreter or Arabic-language assistance, and feedback on how patient feedback makes things better for patients.

The targets for patient experience should be understood in conjunction with the conditions among the workforce and measures of clinical quality. A narrow view of only one patient satisfaction measure would be too limited and could even lead to the hiding of inequalities that exist amongst patients or just surface impression management. It is important to consider safety, workforce, patient experience, access, and reputation measures in a balanced dashboard.

5.3. Limitations

There are various limitations associated with the current article. First, it is an integrative conceptual review rather than a systematic review or causal primary study. Secondly, most of the engagement

data comes from other nations apart from Saudi Arabia, meaning that the generalization should be viewed as a hypothesis. Thirdly, the hospital reputation is multidimensional in nature and hence cannot be captured using patient ratings alone. Fourthly, the studies carried out in Saudi Arabia are regional in nature, cross-sectional, and based on self-reports.

6. CONCLUSIONS

Reputation at Saudi hospitals is expected to rely in part on patient learning from daily care interactions. The findings reviewed suggest that employee engagement through HRM is related to quality-care enabling conditions; and patient experience represents an observable means whereby such internal conditions may be translated into trust and reputation messages. The proposed conceptual framework thus links these areas without exaggeration of causal evidence. The framework considers Saudi-specific boundary conditions in terms of service culture and cultural-communication competence. The main hypothesis here then appears rather simple: sustainable hospital reputation is more reliably created by an engaged workforce delivering respectful and culturally appropriate care than merely by external communication.

Table I: Evidence Synthesis Supporting the Proposed Model.

Link or condition	Synthesis of evidence	Interpretation for the proposed model
HRM resources → employee engagement	Engagement theory stresses meaningfulness, safety and availability; job resources are associated with engagement (Kahn, 1990; Bakker and Demerouti, 2007).	HRM is modelled as an upstream enabling system rather than a separate administrative function.
Employee engagement → care quality/service climate	Reviews show positive engagement–safety/quality associations; the pooled relationship is small and heterogeneous (Janes et al., 2021; Scott et al., 2022).	Engagement should be measured as a predictor, but causal claims require longitudinal or quasi-experimental designs.
Employee engagement → institutional quality signal	Across 97 English acute trusts, engagement predicted regulatory quality ratings (Wake and Green, 2019).	Engagement may have a direct association with reputation through advocacy and visible organisational quality.
Patient experience → quality/trust signal	Patient experience is positively associated with safety and effectiveness; Saudi studies highlight empathy and responsiveness (Doyle et al., 2013; Alghamdi, 2014; Alharbi, 2023).	Patient experience is the principal mediation mechanism between internal conditions and external reputation.
Cultural and communication capability	Saudi evidence identifies language, culture and religion as important communication conditions (Alshammari et al., 2019).	Cultural–communication capability is proposed as a boundary condition, not an afterthought.

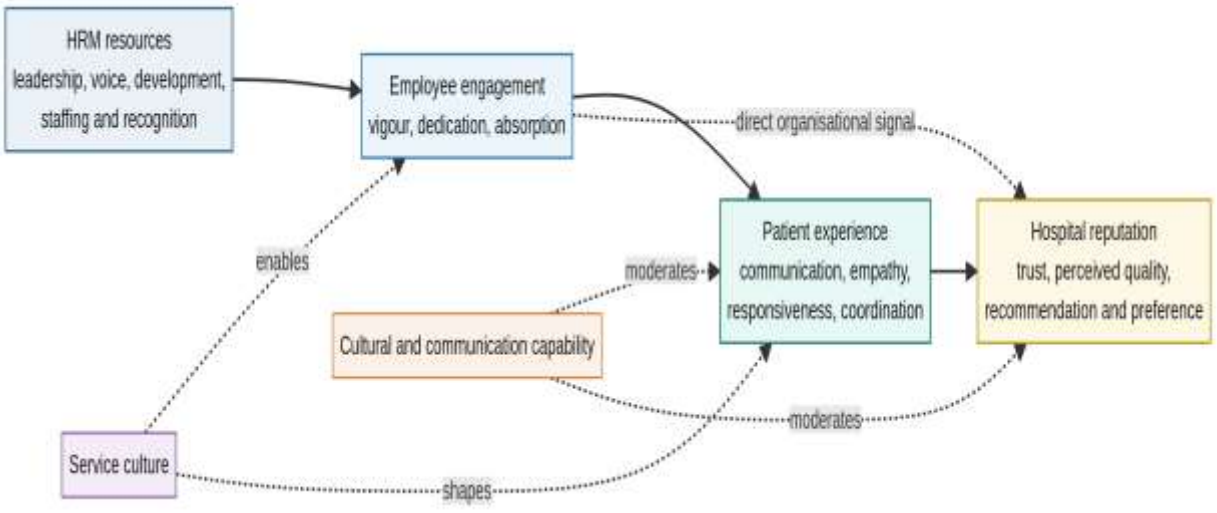


Figure 1: Conceptual Framework Integrating HRM, Patient Experience and Hospital Reputation.

The model has identified six propositions. P1: Human Resource Management Resources have positive relationship with employee engagement. P2: Employee Engagement has positive relationship with Patient Experience. P3: Patient Experience has positive relationship with Hospital Reputation. P4: Patient Experience moderates the positive relationship between Employee Engagement and Hospital Reputation. P5: Patient-focused Service Culture increases the positive relationship between Employee Engagement and Patient Experience. P6: Cultural Communication Capability increases the

positive relationship between Patient Experience and Hospital Reputation.

Table II: Recommended Operationalisation for a Future Saudi Hospital Study.

Construct	Unit and proposed indicators	Example source and methodological safeguards
HRM resources	Staff/unit: supervisory support, development, voice, recognition, workload and staffing adequacy.	Adapted job-resources items; pretest for public/private and professional-group equivalence.
Employee engagement	Individual staff, aggregated to unit: vigour, dedication and absorption.	UWES-9 (Schaufeli et al., 2006); use authorised wording and undertake Arabic validation where required.
Patient experience	Patient, aggregated to unit: communication, respect, involvement, responsiveness, coordination and timeliness.	Culturally adapted patient-experience or SERVQUAL-informed items; sample after comparable episodes of care.
Hospital reputation	Patient/community/stakeholder: trust, perceived competence, patient orientation, social responsibility, preference and recommendation.	Adapt customer-based reputation dimensions (Fombrun et al., 2000; Walsh and Beatty, 2007); keep reputation distinct from immediate satisfaction.
Moderators	Unit/hospital: service climate; cultural–communication capability; Arabic-access support; cultural-humility training.	Use staff audit, training records and patient reports; model interactions rather than treating them only as controls.

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