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Opportunities for the Market Orientation Concept in the Healthcare Service: The Case of Hungary

Market orientation (MO) in the healthcare service has always been subject of extensive debate. This paper is an attempt to expand this issue. For this purpose, we deliver a contrastive analysis on the MO and healthcare context. The paper concludes that:
(a) Considering the new socio-economic contexts, MO can be perceived as an appropriate and applicable model for the healthcare service
(b) Based on the wider definitions of the term customer (namely the internal customer concept), it is ethically appropriate to term patients customers of healthcare service as well
(c) The main challenge of the implementation and institutionalization of MO in the healthcare environment remains to be the method to deal with the perception gaps between the stakeholders of healthcare on their own as well as each others' roles before, during and after their meeting.

INTRODUCTION

The revolutionized demand driven approach to marketing has necessitated a general managerial and organizational reorientation [Lafferty & Hult 2001]. According to this approach, the customers are treated as insiders and are placed atop the decision making pyramid. Therefore, customer satisfaction is taken as the prime measurement for gauging managerial and organizational performance [Grönroos 1989]. In marketing literature, the core of this reorientation has been referred to as 'customer orientation' [Deshpande & Webster 1989], or 'market orientation' [Kohli & Jaworski 1990].

Elsewhere, Lafferty and Hult [2001] have successfully extracted five different major attempts to conceptualize the construct. This extraction leads to the creation of a synthesized MO framework. Graves and Matsuno [1995] had earlier categorized their collections under three distinctive perspectives.

In practice, however, the advantages of a full fledged market orientation (MO) have been widely debated. Furthermore, skeptics have been questioning the universal applicability of MO as far as different organization (i.e. non-profit) and industry types (i.e. healthcare and education) are concerned. The current paper argues that the MO application should indeed be treated universally. In the first part of the paper, we provide references to the universal antecedents of MO are provided and we refer to the extractions of Lafferty and Hult [2001]. We extend the findings of Graves and Matsuno [1995] on MO conceptualization and operationalization as well to be able to create a new definition of MO. Under this definition the importance of optimizing 'stakeholder satisfaction' for the institutionalization of MO has been embraced. This notion had been earlier denoted by some advocates [Deshpande, Farley & Webster 1993], but had not been expanded. In the second part, the healthcare service context is described through a historical perspective. Then, the next important considerations for the operationalization of MO in the healthcare service environment con-

centrate on the importance of doctors, their attitude and perceptions in determining the delivered value.

MARKET ORIENTATION – ANTECEDENTS, DEFINITIONS AND CONTEXT

The origins of the market orientation philosophy can be traced in the writings of advocates such as Felton [1959]. Proponents claimed that organizations adopting such a philosophy would out-perform those who did not [Narver & Slater 1990]. On the other hand, however, the universal applicability of such a philosophy has been a subject of debate for a long time [Henderson 1998]. One of the sectors where the adoption of MO is perceived not to be practicable is the healthcare sector. Since the main area of concern in this paper is related to the demonstration of the importance and positive contributions of MO to the healthcare results, we deliver the background to MO antecedents first and propose an extended definition. After having established the notion, we observe MO in the healthcare environment.

As far as the antecedents of MO are concerned, the most prominent investigations – which confirmed the positive relationship of MO with improved customer satisfaction and overall organizational performance – were carried out by Jaworski and Kohli [1993] as well as Day and Nedungadi [1994] on "large firms", Pelham and Wilson [1996] on "small firms", Narver and Slater [1990] on "product producers", Naidu and Narayana [1991] on "service suppliers", Slater and Narver [1994] on "for-profit" organizations, Wrenn, La Tour and Calder [1994] on "non-profit" organizations. Regarding the impact of the cultural factor on MO, since the acceptance of the concept is necessary for it's future implementation, Rekettye [2000] referred to the well-known study of Hungary in which the impact of the historical culture and form of organizations under communism was proposed to play a role in the slow adoption of MO in post transitional large organizations (mainly governmental). However, Lafferty and Hult [2001] refer to studies supporting the fact that positive antecedents of MO exist independently on the cultural environment. These incidences suggest that the applicability of MO is not determined by the type of organization nor the respective industries and neither the cultural environment.

On the other hand, the attempts to conceptualize the MO definition were only partially successful because content and main focus have been extensive but scattered. The extractions of Lafferty and Hult [2001] also represent a successful categorization of the conceptualization of the various MO constructs. They concluded that there are four general areas of agreement extracted from five perspectives. These perspectives were enlisted as: (1) Customer orientation, (2) Culturally based behaviors, (3) Strategic marketing, (4) Market intelligence, (5) Decision-making process. The extractions suggesting general areas of agreement included: (1) The emphasis of all perspectives on customers, (2) The acknowledgement of the importance of shared knowledge and information by all, (3) The significance of the inter-functional coordination of marketing activities by taking appropriate actions under each of the five perspectives, (4) The central importance given to being responsive to market activities by taking appropriate action is agreed upon by all the mentioned perspectives.

These studies and the extractions of Lafferty and Hult [2001] seem to remain rather short instead of dealing sufficiently dealing with the emerging understandings of value creation and delivery that are expected to belie the MO construct, should it be considered as a strategic and/or process management construct, or even that of a culture. The importance of being responsive to market activities through taking appropriate action was denoted by all perspectives in one way or another, yet the type and capacity of the human factor necessary to be responsive to the contextual drivers or the organizational set up and philosophy were not dealt with.

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The significance of continuous efficiency and effectiveness in creating and delivering value has been an implied if not always stated center of attention. Above all, customer satisfaction was taken as an established measure of performance. These indicate that a responsive model was mainly and merely defined as one which would properly collect, disseminate, and respond to market intelligence [Shapiro 1988]. In their definition of MO, Narver and

Slater [1990] first referred to MO as "the organizational culture which most effectively and efficiently creates the necessary behaviors for the creation of superior value for the buyers, and thus, a continuous superior performance for the businesses". Later they expanded the definition by mentioning the importance of considering the stakeholder interests stating that " MO is the organizational culture which places highest priority on the profitable creation and maintenance of superior customer value, considering the interests of the stakeholders" Elsewhere, Deshpande, Farley and Webster [1993] posited that "customer orientation is the set of beliefs that puts the customers' interest first, while not excluding those of all other stakeholders such as owners, managers and employees, in order to develop a long-term profitable enterprise". The two definitions touch the same intra-organizational as well as extra-organizational issues of our concern: (a) the importance of stakeholder interest which we propose to be identically translated into stakeholder value and measured in terms of their satisfaction. At an operational level in order to compliment the frameworks and definitions of MO we propose to adopt the concept of internalizing the external customers and externalizing the internal customers (treating all stakeholders as customers and creating processes that would optimize satisfaction all across the value chain) [George 1990, Grönroos 1981, Greenley & Foxall 1998]; (b) Regarding the needed long term vision, in order to extend the MO frameworks and definitions we propose the attainment of this aspect to be through with the incorporation of sustainable management models and frameworks.

Amongst the earlier attempts to conceptualize these understandings, Graves and Matsuno [1995] had categorized MO perspectives as follows: (1) An 'objective/mechanistic' perspective, (2) A 'subjective/organic' perspective and (3) An all integrative 'enactment/social-systems' perspective. Their extractions were considered in line with our purpose since a balanced approach on demonstrating the intra-organizational as well as extra-organizational context implying their relevant counter impacts had been devised in their paper.

(1) The 'objective/mechanistic' perspective

From the *objective/mechanistic view* (also referred to as the rational/mechanistic perspective) organizations exist in an objective world and function in a deterministic way within that world. It is assumed that the cognitions and behaviors are linked deterministically. In other words, if the managers, their superiors and/or subordinates perform a particular behavior, this behavior will reflect their specific belief. The primary interest of the rational/mechanistic perspective of MO is to clear up which set of 'activities' an organization undertakes to be market oriented. Finding top management commitment and interdepartmental cooperation important cognitions, MO was operationalized in terms of intelligence-related activities which help to understand and respond to the current and future needs of customers. Examples of such activities are customer intelligence generation and dissemination, and responsiveness to the intelligence. In terms of prescriptions for implementation, the mechanistic perspective suggests – since MO is reflected in particular behaviors – that the organization should allocate resources to be able to learn and perform these behaviors. Thus, the challenge to become market oriented is finding a way to make those behaviors occur [Kohli & Jaworski 1990, Jaworski & Kohli 1993].

(2) The 'subjective/organic' perspective

From the *subjective/organic perspective* organizations exist in a subjective world. An organization is seen as creating its subjective world from the "metaphors and frames of reference that allow the organization and its environment to be understood by organizational stakeholders". Since the world is created subjectively by the members of a particular organization, relations between causes and effects are considered to be idiosyncratic. A critical assumption of the subjective/organic perspective is that organizations are intertwined with their environment.

Thus, organic perspective assumes that elements are linked interactively. Organic perspective suggests that MO be understood in terms of the 'shared meanings of the organization' and 'the culture'. As far as implementation is concerned, 'acceptance' of this philosophy at managerial and organizational level is a necessary condition for its implementation. In this case, organizational culture was defined as "the pattern of shared values and beliefs that help individuals to understand organizational functioning and thus provide the norms of behavior within the organization".

The operationalization of this view was a measure of organizational members' behavioral characteris-

tics and management policies as well as customer orientation which were considered to be synonymous with MO [Narver & Slater 1990, Deshpande, Farley & Webster 1993]. The definition adopted under this perspective was "the organizational culture that most effectively and efficiently creates the necessary behaviors for the creation of superior value to customers and thus, a continuous, superior performance for the organization". The notion that MO is a culture that leads to certain outcomes (i.e., the creation of superior value for customers) is central. In terms of implementation, the subjective organic view suggests that the organization adopt the philosophy or culture of MO. Once this culture is in place, the organization will develop and employ the necessary skills to meet their needs. However, the change to become market oriented is drastic and it requires a change in the fundamental values and beliefs of the organization. In other words, becoming market oriented requires a "reorientation" or "paradigm shift" within the organization.

„Successful implementation would entail a coordinated or balanced development of values and behaviors. Market oriented behaviors, particularly data gathering and dissemination would create the necessary inter-related construct of MO."

(3) The integrated 'enactment/social-systems' perspective

This view suggests a mutually reinforcing relationship between the market oriented culture (value and belief) and the market oriented behaviors which should exist to become significantly market oriented. The 'enactment/social system perspective' proposes that an integrative perspective would capture both the contextual and the behavioral features of MO. This perspective views MO as an interrelated system of organizational values and beliefs and a set of activities that would be consistent with those values and beliefs.

Weick [1969] suggests that organizations "enact" their environments, beyond the perceived subjective fashion. As far as attention is concerned, it should be noted that the managers' understandings of the world and their values and beliefs guide attention which is subjective in this sense. In referring to action under this perspective, devising actions that create the world are considered to be in an objective manner.

This view suggests that understanding organizations requires an explanation of both 'attention' and 'action'. To put it another way, it is to assess the 'perceptions' of the organization and the 'activities' undertaken by the organization. In terms of measuring MO, both behaviors and values should be assessed. Implementing MO would entail the development of values and beliefs and the learning of skills. Values and beliefs and behaviors are seen as mutually reinforcing. Without instilling the necessary values and beliefs into people, 'market oriented" behaviors would be understood under other forms of orientation. For example, members of the organization may understand these behaviors as necessary to appease upper management rather than to satisfy customers and be market oriented. Without the necessary behaviors, 'market oriented' values would not have the support needed to be sustained.

Successful implementation would entail the coordinated or balanced development of values and behaviors. Market oriented behaviors, particularly data gathering and dissemination would create the necessary inter-related construct of MO.

Extensive evidence on the impact of MO in the internal and external context is available. Lichtenthal and Wilson [1992] assert that MO impacts internally on employees and externally on customers. The same advocates also consider that MO has significant internal consequences for organizational and individual behavior. Mengüç [1996] found that by improving the MO of the organization, job satisfaction and employee commitment are improved, in the same way as the customer orientation of the 'contact personnel' is due to reduced role stress (both role conflict and role ambiguity) which is associated negatively with job satisfaction and employee commitment.

Siguaw, Brown and Widing [1994] argue that market orientation impacts positively on employees' levels of customer orientation, job satisfaction and organizational commitment and impacts negatively on employees' role stress. They claim that organizational and individual behaviors are important factors in developing and maintaining a MO. The role of management in developing appropriate systems and

structures for MO is particularly emphasized. This role includes the use of appropriate human resources policies (recruitment, training and rewards systems) to foster market oriented attitudes and beliefs, the development of a market-oriented culture, the reduction of interdepartmental conflict and barriers, and the development of interdepartmental co-ordination and communication.

Martin, Martin and Grbac [1998] confirm the assertion that employees influence the MO of the organization at all levels and in all functions. Similar studies stress that the most important stakeholder interface is that between the contact employees and the customers. When the organization in question is a service provider, the value of the interface to market orientation gains an even greater importance. In this sense the contact people create and/or highly influence the customer's perception regarding the organization. On the other hand, getting closer to the customers especially in service situations, will require the service providers to optimize the customer's involvement in the production of the service.

Gummesson [1996] refers to such customers as the *imaginary employees* of the organization. It should be noted that if the external customer is treated as an employee and involved in joint production of the service, then this imaginary employee (the customer) needs to be managed and trained to ensure that they are effective. This management and training of imaginary employees will be the responsibility of the contact employees who have the most contact with them. Understanding the sensitive role of the contact personnel, it will be upon the management to ensure that careful recruitments are considered and that sufficient efforts are made to be able to secure happy and motivated front line employees. As an example in the healthcare service, a study by Braunsberger and Gates [2002] proved a strikingly strong and pivotal role of physicians in influencing patient satisfaction in healthcare.

The aforesaid are of central value for our purpose: first, as it was discussed, the contributions of MO to improved overall performance (not just short term profitability) can be considered universal (independent of organization type, size, sector) which confirms the validity of the observation of MO in the healthcare service. Secondly, the indications of the decisive role of contact employees on MO level, especially that of doctors in the healthcare environment

MARKET ORIENTATION IN THE HEALTHCARE SERVICE ENVIRONMENT

Perhaps the core concern of skeptics in connection with the universal applicability of MO, especially in the healthcare service, resonates with the perceptions of the ultimate goal of healthcare and with the question whether a patient could be termed the customer or consumer of the healthcare service. More precisely, the question is that if a patient could be defined as: "a person who is ill, or believes him or herself to be ill (and/or the society or friends and family consider him/her as ill) and who seeks the expertise of a doctor or the technical treatment provided by him to be able to challenge or overcome the illness". Is it ethical to treat her/him as a customer? If so, solely based on welfare economics' understandings, would it be ethical to consider a marketing plan that aims at maximizing our profits through serving the imaginary or actual sick? On the other hand, another problematic area which has been the source of debate is the role of the doctor or caretaker in serving the patient. In other words, the question is, if doctors are for example: "mere consultants rendering their services to whomever who seeks such service; or are they decision makers, appointed by the tax payers to make deci-

Table 1.
Contrasting doctors' and patients' perceived and expected roles

	Perceived Historical Role		Expected Emerging Role	
	Doctors	**Patients**	**Doctors**	**Patients**
Doctors	***Autonomous-Decision Maker***	***Inferior, waiting for orders***	Autonomous-Decision Maker	Inferior, waiting for orders
Patients'	The Curer	Ill, seeking help	***The guide, consultant***	***Seeking care, service, advice***

sions on behalf of the society in order to cure or prevent the diseases".

Parsons [1951] was one of the earliest sociologists who examined the relationship between doctors and patients. The following levels can be extracted from Parsons' writings:

1. The core unit of medical practice is the doctor-patient meeting which includes intimacy. Therefore, the doctor should prove worthy of patients' trust and confidence
2. Their success depends not only on the doctors' clinical knowledge and technical skills, but also on the nature of the 'social relationship' that exists between doctor and patient
3. Traditionally doctors enjoyed higher authority in their relationship with patients
4. Doctors are expected to apply their knowledge to the benefit of the patient and the welfare of the community, not to benefit of their own interests
5. Conflicts may arise from the differences in personal values of doctors and patients

Since Parsons' writings, as a consequence of the increase in the breadth of market based economies, societies' have shown changing patterns regarding their expectations. On the other hand, with regard to the prescriptions of the market driven economies, having commented for example on the third conclusion above, as service providers, the doctors may not necessarily enjoy the 'higher authority' position in comparison to the patients.

Roter and Hall [1992] argued that a relationship – which accepts that the patients' unique knowledge is important – can benefit from better outcomes. The doctors' perception in each party's role and the goal of treatment (patient or illness) has important consequences, and will actually determine the approach of the doctor when communicating with the patient.

Lown [1996] showed that patients desire to be known as a human being, not merely to be recognized as the outer wrappings for a disease. Other research highly supports superior outcomes of a patient oriented approach which respects patients' wants and needs even more. According to the same study doctors who encouraged patients to talk about psychosocial issues such as family and job had more satisfied patients and the visits were not longer as an average of two minutes. A separate study [Marvel et al 1999] shows that last minute questions occurred less frequently when the patient was invited to talk. Further confirmations claim that the health of the doctor-patient relationship is the 'best predictor' whether the patient will follow the doctor's instructions and advice [Korsch & Harding 1998].

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"... doctors prefer rather talking than listening to their patients. ... 72% of the doctors interrupted the patient's opening statement after an average of 23 seconds (patients who were allowed to state their concerns without interruption used only an average of 6 more seconds). ... doctors often ignore the patients' emotional health. [It was] found that when patients dropped emotional clues or talked openly about emotions, the doctor seldom acknowledged their feelings. Instead, the conversation was directed back to technical talk. .. Doctors have traditionally been taught to regard patients as 'unreliable narrators' and to chart patient observations in a subjective language that implies a certain skepticism, such as 'the patient believes' or 'the patient denies'."

Incidentally, doctors also benefit from the patient-centered approach, researchers note, because they feel more job satisfaction and are less likely to

burn out. Unfortunately, by large, doctors tend to disregard the fact that many chronic illnesses can be 'managed', but 'not cured', not because they are delinquent in learning, but because science did not reach that state of development [Lown 1996]. Therefore, in general terms, adopting an illness treatment focus as opposed to that of a patient treatment is indeed dangerous for both parties and eventually for the community at large.

According to a study by Korsch and Harding [1998] doctors prefer rather talking than listening to their patients. A recognized study by Marvel et al. [1999] found that 72% of the doctors interrupted the patient's opening statement after an average of 23 seconds (patients who were allowed to state their concerns without interruption used only an average of 6 more seconds). Suchman et al. (1997) showed that doctors often ignore the patients' emotional health. This study found that when patients dropped emotional clues or talked openly about emotions, the doctor seldom acknowledged their feelings. Instead, the conversation was directed back to technical talk. The 'legal context' of medical practice has also been subject to change. It is justified that doctors feel constrained in connection with severe malpractice laws. However, there is evidence that the doctors' communication skills through which patient information was carefully received and treatment alternatives delivered by the doctors, as well as stakeholder perceptions influenced positively the event against malpractice [Beckman et al. 1994]. Roots of such problems may go back to the unchanged culture of approaching communication with patients. Doctors have traditionally been taught to regard patients as 'unreliable narrators' and to chart patient observations in subjective language that implies a certain skepticism, such as "the patient believes" or "the patient denies" [Toombs 1992]. Having interviewed many doctors, they perceive 'time' to be their main constraint for the lack of their customer oriented attitude. Waitzkin [1984] showed that doctors underestimate the amount of information patients want and overestimate how much they actually give. The same study covered 20-minute office visits: interestingly, doctors spent only about one minute per visit informing patients but they believed they were spending nine minutes per visit doing this. Implications of these extractions for the new context of healthcare may be summarized as follows:

1. Health results depend on: (a) the patients' understanding of the doctors' prescriptions, (b) the patients' feeling of comfort when communicating with the doctor, and the feeling of trust and confidence in the doctor(c) the patients' willingness to cooperate with the doctor (d) As a multi component factor patients' satisfaction leads to improved health results
2. The doctor is not a superior authority because (a) There are a big range of illnesses and potential treatments which are also unknown to the doctor at any given time and place. So their expertise is not absolute (b) Normally, (except emergency cases) either the patients or their family and friends select the doctor and not vice versa (c) patients own the disease or problem (d) They bear the costs of the service in a direct or indirect manner (e) Their cooperation before, during and after treatment as well as their knowledge (information) is at least identically important to accomplish the goal of care. (if not more)
3. An extensive misconception and ambiguity on the side of both the patients and doctors is existent. This factor has a negative impact on reaching an efficient cooperation. The levels and types are hypothesized in the table (3) below.

Table 2
Summary of identified categories which deserve a perception gap analysis

1. ***general perceptions in the central goal of healthcare*** (treating 'patient' vs. 'illness', 'cure' vs. 'satisfaction')
2. the care providers' ***approach to communication and partnership*** (a doctor who discusses and agrees the problem and treatment, likeable and interested in patient's worries and expectations)
3. ***personal relationship*** (doctor who knows the patients and their emotional needs)
4. ***health promotion*** (ways to prevent risks and future illnesses)
5. ***positive and clear approach to the problem*** (being definite about the problem and how it could be settled)
6. ***interest in the effects on patient's life*** (interested in the effects on everyday life and family)
7. ***general perceptions in the constraints*** encompassing the care giver (time, number of caregivers employed, number of logistics personnel, organizational rules and healthcare laws)

4. Since the patient-doctor meeting involves intimacy, the cases where the cooperation is successful may result in a social bonding and satisfaction of the doctor as well.

CONCLUSION

Referring to our earlier discussions on the definitions and impact of MO we are able to conclude the following:

1. In connection with the new socio-economic context and the changing expectations, as far as the objectives and definition of MO are concerned, MO will positively contribute to the optimalization of the healthcare results. This is mainly because the basic goal of MO is also to enhance performance through optimizing stakeholder satisfaction.
2. Under MO a customer is defined as the party seeking values which satisfy his/her wants and needs. In this sense, under MO employees treat each other based on a customer-vendor relationship. In this case, money is not necessarily involved in the transaction. In this sense without any breach of ethics, a patient may also be referred to as a "customer" because he or she directly covers the costs of treatment or they are covered through insurance. In addressing the paradox of calling the aggregated patients the market and the ethically negative connotation of a bigger market in the case of healthcare, (which would mean more patients) we believe that there is a sharp distinction between "the promotion of illness and diseases to expand the available market", as an organizational goal and that of MO which is "to optimize stakeholder satisfaction" which would lead to ethically as well as economically sound results
3. The importance of examining perceptions was stated under the *'organic'* as well as *'social perspectives'* of MO. Nevertheless, as observed, a considerable gap exists between the perceptions of doctors and patients in their own and each others' roles in approaching their cooperation. Therefore, the main challenge towards the implementation and institutionalization of MO should be to identify and overcome these perception gaps.
4. Considering the prescriptions of the *'mechanistic'* as well as the *'social perspective'* of MO: as far as implications for management are concerned, measures such as redefining recruitment policies (that would lead to the employment of doctors with higher empathy) and including MO based performance measurements, appraisals training and development would be advised in order to improve the MO culture and behaviors.

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