1. Introduction

The service sector plays an increasingly important role in modern economies. Consequently, service managers and academic researchers are now directing their efforts to understanding how customers perceive the quality of services. The issue of health-care quality management has drawn considerable attention from both academics and practitioners over the past few years. In the wake of pressure to move towards a managed care environment, health-care providers are being forced to drive down costs, while at the same time maintain acceptable levels of quality. Health care administrators must contain costs, yet at the same time not sacrifice quality. Consequently, the ability to define, measure, and monitor quality is critical to the survival of health-care institutions.

Rust et al. (1995) suggested that superior service quality helps to generate greater revenue and yield greater profitability. In short, superior service quality has a positive effect on business profitability. Because both market orientation and service quality moderate offerings and have a positive impact on business profitability, a subsequent question is how market orientation and service quality are related. Conceptually, one immediate effect of the offering modifications is a firm’s improved ability to satisfy customers’ needs effectively by realizing what they want. Better served customers are likely to make repeat purchases and spread out positive word-of-mouth information to potential new customers. Another direct effect of the offering modifications is the increased capability to serve customers efficiently by eliminating or reducing nonessential services by learning what customers do not need. The enhanced effectiveness and efficiency of the service offering can then lead to stronger profits due to higher revenue and lower cost. Consequently, the strength of the market orientation-business performance relationship will depend on how much added effectiveness and efficiency can be accomplished by the market oriented effort. And a direct gauge of the effectiveness for service firms is service quality.

1.1 Health service’s nature and value

Like quality in most services, healthcare quality is difficult to measure owing to inherent intangibility, heterogeneity and inseparability features (Conway and Willcocks, 1997). Butler et al. (1996) reiterate Zeithaml (1981, pp. 186-190) that patients participating in production, performance and quality evaluations are affected the current issue. Healthcare is dynamic –
considerable customer changes have taken place and competition is increasing (Gilbert et al., 1992). Consequently, healthcare quality evaluations raise problems owing to service size, complexity, specialization and expertise within healthcare organizations (Eiriz and Figueiredo, 2005).

Generally, purchases can be categorized as having search, experiential and credence properties (Nelson, 1974). Specifically, healthcare is by nature a credence purchase (Butler et al., 1996). Patients may be unable to assess medical service technical quality accurately; hence, functional quality is usually the primary determinant. Also, healthcare quality is more difficult to define than other services such as financial or tourism mainly because it is the customer himself/herself and the quality of his/her life being evaluated (Eiriz and Figueiredo, 2005). Some authors suggest that healthcare quality can be assessed by taking into account observer, i.e. friends and family perceptions. Moreover, these observer groups represent potential future customers – major influencers of patient healthcare choices (Strasser et al., 1995).

1.2 Healthcare quality and satisfaction

Patient determined quality literature inconclusively predicts the direction of satisfaction and quality from the patient’s perspective (Tucker and Adams, 2001). Quality is positively correlated with satisfaction; however, the direction and strength of the predictive relationship between quality and satisfaction remains unclear, it shows that complex healthcare services and the patient’s lack of technical knowledge to assess them should incorporate broader healthcare quality measures, including financial performance, logistics, professional and technical competence (Eiriz and Figueiredo, 2005). Quality is a judgmental concept (Turner and Pol, 1995) and operational quality definitions, as we have seen, are based on values, perceptions and attitudes (Taylor and Cronin, 1994). The implication thus is to develop quality measures based on expert judgement, specifically insightful customers and respected practitioners (Turner and Pol, 1995). Consequently, healthcare quality can be categorized in three ways (Donabedian, 1986):

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Individual healthcare quality measures include (Donabedian, 1986): Structure – the medical delivery system’s fixed characteristics such as staff number, types, qualifications and facilities. Process – what is done to and for the patient such as treatment? Outcomes – changes in the patients’ current and future health attributed to antecedent medical care.

Existing academic research of health care providers reveals different consumer behaviour patterns than within those services that are less personal and less professional. Above all, due to the nature of medical care, consumers use health care systems such as hospitals out of need and not choice. Individuals feel unable to make choices about their treatments, with many feeling comfortable in being passive and leaving all potential decisions to the nurse or physician in charge (Gandjour, 2007; Puro, 1996; Shortell et al., 2007). Thus, healthcare service, unlike other non-professional services, is low in search attributes; that is to say, attributes that can be evaluated by the customer before selecting a hospital or alternative health care provider or experiencing service. Likewise, medical care is also low in experience (familiarity) attributes, or attributes that can be evaluated after experiencing the service but not before (Budd and Raber, 1996; Hunter and Schmidt, 1990; Lilford et al., 2007; Hunter et al., 1982); instead, the medical service has more credence (credibility) attributes, which cannot be confidently evaluated sometimes even after experiencing the service, because of the technical nature of the service. So here focus for evaluation of quality of services is only on perception of quality of services of patients or attendants instead of finding gap between Expectation and Perception of quality of services.

1.3 Health care quality

In our view, health care quality can be studied at two different levels. At one level, it can be assessed as a performance issue related to the entire health care system. At the organisational level, on the other hand, actors such as patients and doctors involved in service delivery can assess health care quality. We will start by discussing health care quality at the health care system before focusing on the organisational level.

This framework provides a vision of health system quality problems, because system quality and system equity are not always the same. In other words, it is important to separate and consider both technical and human aspects in order to develop a global view of quality of care.
Another aspect is the level of customer expectation in terms of health care responsiveness. Positive health care outcomes, such as life expectancy are growing, which contributes to a constant increase in customers’ expectations. This can create irrational relationships: improved outcomes (for example, increased life expectancy) could mean a demand for an additional level of outcomes (in the same example, a more desirable life expectancy). At a certain point, this may bring some disappointment when expectations are not met (when a person dies prematurely) and a consequent perception of lower quality. Although a broad approach to the study of health care quality requires an analysis of performance at the level of the health care system, our main concern is with the organisational level, given that “patients’ expectations and priorities vary among countries and are highly related to cultural background and to the health care system” (Salomon et al., 1999, p. 507). At the organisational level, customers traditionally define quality. In short, it is customer-perceived quality that has to be studied. Garvin’s (1988) different approach was based on the idea that quality depends on the context; that is, quality is largely a co-ordinated effort within an organisation. However, as mentioned by Lovelock et al. (1999), Garvin’s research was targeted at manufacturing. Parasuraman et al. (1985) studied services and identified ten criteria used by consumers when they evaluate service quality. In 1988, they classified them as five broad dimensions:

(1) Tangibles (the appearance of physical elements);
(2) Reliability (dependable, accurate performance);
(3) Responsiveness (promptness and helpfulness);
(4) Assurance (competence, courtesy, credibility and security); and
(5) Empathy (access, communications and customer understanding).

In the context of health care services, Baron-Epel et al. (2001, p. 317) concluded that “the relationship between the patient and the treating physician is based upon the mutual goal of optimising the patient’s health” and concluded that “the higher the perceived fulfilment of the expectation is, compared to the expectation, the higher the satisfaction is”. Next, we will discuss measuring health care quality at the organisational level.
1.4 Market orientation

Market orientation implies that a business obtains information from customers about their needs and preferences and then takes action based on that information, while considering competition and regulations. In a dynamic marketing environment, marketers continuously modify their offering mix in response to and/or in anticipation of changing needs and competitors’ actions. Such consistent efforts by a market-oriented firm narrow the perceptual gap between the firm’s management and its customers (Zeithaml et al., 1990). Day (1994) points out that market sensing, which systematically gathers, interprets, and uses market information, is a distinctive capability of a market driven organization. Similarly, Kohli and Jaworski (1990) define market orientation as “the organization-wide generation of market intelligence, dissemination of its intelligence across departments, and organization-wide responsiveness to it”. Service providers more oriented to their markets are likely to make changes to meet or exceed customer expectations. Therefore, premium service quality is expected to be an end result of a market-oriented service firms.

1.5 Development of market orientation Concept

Kohli and Jaworski (1990) defines market orientation as the organization-wide generation of market intelligence pertaining to current and future needs of customers, dissemination of intelligence within an organization and responsiveness to it. These authors therefore define (and measure) this concept through three basic components activities / processes) dealing with marketing information: their generation, dissemination and responsiveness.

A slightly different definition was proposed by Narver and Slater (1990). They define market orientation as the organizational culture that most effectively and efficiently creates the necessary behaviours for the creation of superior value for buyers and thus superior performance for business. These authors define three basic (content / focusing) components of the construct as: customer orientation, competitor orientation and inter-functional coordination. To the three basic components they also added two decision criteria: long-term focus and profitability.

Deshpande, Farley and Webster (1993) challenged both conceptions. They see market orientation as being synonymous with customer orientation, being distinguishable from competitor orientation. Putting customer interests first is the central part of their definition of
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customer (market) orientation and they argue that competitor orientation can be almost antithetical to customer orientation when the focus is more on the strengths of the competitor than on the unmet needs of the customer. This view is consistent with other authors from the marketing and strategic management field. They emphasize a need for a strategic focus which should be on the customer (Ruekert, 1992, Christoper et al., 1991, Karloef, 1993, Day, 1994, Doyle, Wong, 1996).

Critical discussion stimulated different improvement efforts in measuring market orientation. Deng and Dart (1994) developed a four-factor instrument, consisting of the three factors of Narver and Slater (1990), to which they add (actually, put back) profit orientation as a fourth substantive dimension.

Gray et al. (1998) proposed a five-factor instrument which combines the Kohli and Jaworski (1990) and Narver and Slater (1990) dimensions. The dimensions of their instrument are inter-functional co-ordination, profit emphasis, competitor orientation, customer orientation and responsiveness. Lado et al. (1998) added distributor orientation and environmental orientation to the concept, and proposed a nine-component model which encompass two stages of the market orientation process: analysis and strategic actions (each consisting of four components), plus an additional component, intra-functional coordination. Altogether the nine components proposed by Gray et al. (1998) are: Analysis of the final client, Analysis of the distributor, Analysis of the competition, Analysis of the environment, Inter-functional co-ordination, Strategic actions directed toward the final client, Strategic actions directed toward the distributor, Strategic actions directed toward the competition, Strategic actions directed toward the environment.

1.6 Market Orientation & Learning Orientation

Narver et al. (1998) suggests that market orientation could be developed through organizational learning. He suggests two approaches for improvement of market orientation – each of them represents a different form of learning. The first approach is focused on establishing market orientation principles that are later communicated and trained for development of necessary skills and knowledge. A are particularly important for conceptual development of the market second approach focuses on direct interaction with the market and stresses personal involvement and experimentation as a learning method. Deshpande (2001) also emphasizes the importance of creation, diffusion and utilization of marketing
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information, but under a different term - knowledge management. However, empirical studies on the effect of market-orientation on superior performance revealed inconsistent results (Han et al., 1998). For instance, Narver and Slater (1990) and Ruekert (1992) found a positive relationship, Hart and Diamantopoulos (1993) found no relationship, and Kohli and Jaworski (1993) found mixed results. Accordingly, scholars attempted to identify the mechanisms or factors that transform market-orientation behavior into firm performance in their theoretical and empirical models (Han et al., 1998).

One of the most studied factors, which has synergy with market-orientation, is learning-orientation. Many researchers (e.g. Slater and Narver, 1995; Baker and Sinkula, 1999; Farrell, 2000), for instance, argued that market-orientation only enhances performance when it is combined with a learning-orientation. According to Baker and Sinkula (1999, p. 412), learning-orientation is a mechanism that directly affects a firm’s ability to challenge old assumptions about market and how a firm should be organized to address it.” Specifically, since market-oriented firms focus on customers and their feedback in the established markets, they ignore the emerging markets, technologies, and competitors. However, learning-orientation, embracing the commitment to learning, shared vision, open-mindedness and inter-organizational knowledge sharing, fosters a set of knowledge-questioning and knowledge-enhancing values that leverage the adaptive behaviors provided by market-orientation to a higher-order learning that leads to the development of breakthrough products, services, and technologies, and the exploration of new markets (Farrell, 2000; Slater and Narver, 1995).

In addition, to learning-orientation, another mechanism emphasized by the management and marketing scholars is firm innovativeness, which refers to that portion of a firm’s culture that promotes and supports novel ideas, experimentation, and openness to new ideas (Calantone et al., 2002). For instance, Slater and Narver (1995) propose innovation as one of the core-value creating capabilities that drives the market-orientation and performance relationship. Kohli and Jaworski (1993) note that market-orientation provides something new or different in response to market conditions, which can be seen as a form of innovative behavior. Also, by investigating 134 banks, Han et al. (1998) found that innovativeness mediated the relationship between.
1.7 Market-Orientation & Business Performance

In short, scholars in general management and marketing literature support the interrelated relationships among market-orientation, learning-orientation, firm innovativeness, and their combined impact on firm performance in large firms. However, we know surprisingly little about the interrelationships among market-orientation, learning-orientation, innovativeness, and firm performance in Multi Specialty Hospitals.

To address deficiency, the present study extends the model of Calantone et al. (2002) which addressed the role of learning-orientation in firm innovativeness and firm performance. By using some Multi Specialty Hospitals, the authors found that learning-orientation has a positive influence on firm innovativeness and performance; further, that firm innovativeness has a positive impact on firm performance. However, Calantone et al. (2002, p. 523) noted that their study was limited, and that, the general outline can be applied to other types of activities, such as marketing, and their linkage with organizational learning.” They also suggested the applicability of the learning and innovation constructs to other cultures and industries. In this vein, this study adapted the model of Calantone et al. (2002) by incorporating the market-orientation as skeleton Capabilities in Multi Specialty Hospitals for a model of market-orientation, learning-orientation, innovativeness, and firm performance.

The marketing is not trying to sell someone something they don’t want; it is trying to meet consumer needs. Hence, it is very important for a hospital to make efforts for focusing on and assess the needs of the patient. I plan that adoption of a market orientation will result in improved service quality (Chang and Chen, 1998), and I wish to empirically test this across a different hospitals. Services are normally neither produced nor delivered in the same way that physical product. The process and consumption of services are parallel and cannot be separated (Rathmell 1974). Service quality has been found to positively impact customer satisfaction, which in turn leads to improved organizational performance (Cronin and Taylor, 1992; Lee and Hwan, 2005).
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1.8 Service Quality

(“A conceptual framework of service quality in healthcare Perspectives of Indian patients and their attendants” Panchapakesan Padma, Chandrasekharan Rajendran and L. Prakash Sai).

Quality is another factor that has a significant impact on business performance. A number of studies have provided valuable empirical support for a positive quality-profitability relationship (e.g., Buzzell and Gale, 1987; Phillips et al., 1983). Specifically, quality is found to be the most influential determinant of a strategic business units (SBU’s) performance. For services, Zeithaml et al. (1996) found that service quality has a strong positive effect on respondents’ loyalty to the company and a negative effect on propensity to switch. Rust et al. (1995) suggested that superior service quality helps to generate greater revenue and yield greater profitability. In short, superior service quality has a positive effect on business profitability. Because both market orientation and service quality moderate offerings and have a positive impact on business profitability, a subsequent question is how market orientation and service quality are related. Conceptually, one immediate effect of the offering modifications is a firm’s improved ability to satisfy customers’ needs effectively by realizing what they want. Better served customers are likely to make repeat purchases and spread out positive word-of-mouth information to potential new customers. Another direct effect of the offering modifications is the increased capability to serve customers efficiently by eliminating or reducing nonessential services by learning what customers do not need. The enhanced effectiveness and efficiency of the service offering can then lead to stronger profits due to higher revenue and lower cost. Consequently, the strength of the market orientation-business performance relationship will depend on how much added effectiveness and efficiency can be accomplished by the market oriented effort. And a direct gauge of the effectiveness for service firms is service quality.

The results are expected to shed some light on how market orientation, service quality, and business performance are related and to offer important managerial implications for marketing practitioners.

Service quality may be considered to be the ‘feel good’ factor, which is perceived by customers during the process of service delivery. It is what the customer perceives while receiving services from the provider. Through high-quality service, an organization can show its customer that it truly cares.
Introduction

Service providers need to have up-to-date equipment, visually appealing facilities and well-dressed and neat employees. The customer-focus dimension of market orientation includes the ability of the service provider to show that it exists primarily to serve customers (Green and Inman, 2006).

Ghobadian et al. (1994) posit that most of the service quality definitions fall within the “customer led” category. Juran (1999) elaborates the definition of customer led quality as “features of products which meet customers’ needs and thereby provide customer satisfaction.”

As service quality relates to meeting customers’ needs, we will be looking at “perceived service quality” in order to understand consumers (Arnauld et al., 2002). Grönroos (1984) and Parasuraman et al., (1985) looks at perceived quality of service as the difference between customers’ expectation and their perceptions of the actual service received.

Other researchers look at perceived service quality as an attitude. Arnauld et al., (2002) defined perceived quality “whether in reference to a product or service” as “the consumers’ evaluative judgment about an entity’s overall excellence or superiority in providing desired benefits” (p. 327). Hoffman & Bateson (2001) defines service quality as an attitude “formed by a long-term, overall evaluation of a performance”. Attitude is defined as “a consumer’s overall, enduring evaluation of a concept or object, such as a person, a brand, or a service.” (Arnauld et al, 2002) Service quality as “an attitude” is consistent with the views of Parasuraman et al., (1988), Cronin & Taylor (1992) & Sureshchandar et al., (2002). Basis of the view is elaborated by the latter:

“As perceived service quality portrays a general, overall appraisal of service i.e. a global value judgment on the superiority of the overall service, it is viewed as similar to attitude.” (p. 364)Feinburg & de Ruyter (1995) pointed the importance of adapting the definition of service quality in different cultures. Ueltschy & Krampf (2001) contended that differences in culture affect measure of quality in a service sector. They encapsulated service quality measures as “culturally sensitive” and “may not perform properly or comparatively in a culturally diverse group domestically or abroad” (p.22). Cultural factors are said to have greater influence on people’s evaluation of services than on their evaluations of physical goods due to involvement of customer contact and interaction with employees while a service
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is delivered (Mattila, 1999). Feinburg & de Ruyter (1995) postulated that the differences “require adapting service quality to an international setting” (p. 4).

Several studies seem to conclude that satisfaction is an affective construct rather than a cognitive construct (Oliver, 1997; Olsen, 2002). Rust and Oliver (1994) further defined satisfaction as the “customer’s fulfillment response,” which is an evaluation as well as an emotion-based response to a service. It is an indication of the customer’s belief on the probability of a service leading to a positive feeling. While Cronin et al. (2000) assessed service satisfaction using items that include interest, enjoyment, surprise, anger, wise choice, and doing the right thing.

1.9 Service Quality & Business performance

Zeithaml et al. (1990) observed that leading US service companies are obsessed with service excellence. Excellent service is a key to being different, productive, and efficient, and it can pay off richly. Empirically, the relationship between quality and profitability has been acknowledged by a series of PIMS studies (e.g., Buzzell and Gale, 1987; Phillips et al., 1983). The acknowledged relationship provides a strong incentive for firms to improve quality. Buzzell and Gale (1987) suggested that achieving superior quality has three competitive advantages:

(1) Premium price;
(2) Resources for R&D; and
(3) Better customer value.

Building on the PIMS data, Phillips et al. (1983) demonstrated that the quality of a SBU’s products and services is the most important factor affecting the unit’s performance. They suggested that superior quality yields higher profits via premium prices and is an effective way for the unit to grow. Buzzell and Gale (1987) further reported that quality is related not only to profitability but also to growth because of the impact of quality on perceived value. In a multicompany empirical study, Zeithaml et al. (1996) found that service quality has a strong effect on behavioral intentions: subjects’ loyalty to the company (+), propensity to switch (−), willingness to pay more (+), and external response to problem (−). Rust et al., (1995) proposed a model of service quality improvement and profitability. Based on their model, service quality improvements lead to higher customer satisfaction and retention rate,
generate greater revenue and market share, achieve cost reduction, attract new customers and yield greater profitability. In conclusion, superior service quality has a positive effect on business profitability.

1.10 Interrelationships between Market orientation, Service Quality, and Business Performance

A number of studies have provided valuable empirical support for a positive quality-profitability relationship (e.g., Buzzell and Gale, 1987; Phillips et al., 1983). Specifically, quality is found to be the most influential determinant of a strategic business unit’s (SBU’s) performance. For services, Zeithaml et al. (1996) found that service quality has a strong positive effect on respondents’ loyalty to the company and a negative effect on propensity to switch. Rust et al. (1995) suggested that superior service quality helps to generate greater revenue and yield greater profitability. In short, superior service quality has a positive effect on business profitability. Because both market orientation and service quality moderate offerings and have a positive impact on business profitability, a subsequent question is how market orientation and service quality are related. Conceptually, one immediate effect of the offering modifications is a firm’s improved ability to satisfy customers’ needs effectively by realizing what they want. Better served customers are likely to make repeat purchases and spread out positive word-of-mouth information to potential new customers. Another direct effect of the offering modifications is the increased capability to serve customers efficiently by eliminating or reducing nonessential services by learning what customers do not need. The enhanced effectiveness and efficiency of the service offering can then lead to stronger profits due to higher revenue and lower cost. Consequently, the strength of the market orientation-business performance relationship will depend on how much added effectiveness and efficiency can be accomplished by the market oriented effort. And a direct gauge of the effectiveness for service firms is service quality.

The results are expected to shed some light on how market orientation, service quality, and business performance are related and to offer important managerial implications for marketing practitioners.
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1.11 Interrelationships between Service quality, Satisfaction, and Behaviour Intension

Assuming that service quality and satisfaction are distinct constructs, there seems to be no clear message in the literature on the causal ordering of service quality and satisfaction, and on which of the two constructs is a better predictor of behavioral intentions (Bolton and Drew, 1991; Cronin and Taylor, 1992). One group of researchers upholds that satisfaction is antecedent to service quality. Another group of researchers who believe that service quality is antecedent to satisfaction argue that since service quality is a cognitive evaluation, a positive service quality perception can lead to satisfaction, which may in turn lead to favourable behavioral intentions (Brady and Robertson, 2001). A third perspective maintains that there is a non-recursive relationship between service quality and satisfaction (Taylor and Cronin, 1994). In essence, this perspective holds that neither of the two constructs is an antecedent or superordinate of the other.

Interestingly, Dabholkar (1995) suggested that the antecedent role of service quality and satisfaction is situation specific and that if a consumer is cognitive oriented, he or she will perceive the relationship as service quality causing satisfaction, whereas if a consumer is affective oriented he or she will perceive the relationship as satisfaction causing service quality.

Their results suggest that the SQ ! SAT causal order holds well across diverse cultures. Moreover, a preponderant evidence of research results tends to support the SQ ! SAT model (see CBH, 2000, pp. 195-6 for a comprehensive discussion). Whatever may be the causal ordering of these two constructs (SQ and SAT), many authors conclude that both service quality and satisfaction have direct links to behavioural intentions (CBH, 2000; DST, 2000; Cronin and Taylor, 1992). Opinions are however mixed as to whether service quality has a direct relationship with behavioural intentions in all service contexts. Using the overall sample from six industries (spectator sports, participative sports, entertainment, health care, long-distance carrier, and fast food), Cronin et al. (2000) concluded that direct link between service quality and behavioural intentions is significant. However, when the data for the industries were tested separately, the same authors found that “service quality had a direct effect on consumer behavioural intentions in four of the six industries with exceptions being the health care and long-distance carrier industries.” An earlier study by ZBP (1996)
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confirmed a positive relationship between overall service quality and price sensitivity (behavioural intentions).

To summarize the above, the main issue is whether the indirect effect of service quality on behavioural intentions (i.e. SQ ! SAT ! BI) is so significant as to warrant treating customer satisfaction as a required mediating construct between service quality and behavioural intentions in the context of the service factory. Since the service factory has low levels of customer interactions/customizations, opportunities for direct customer-service employee encounter episodes are fewer, suggesting that the direct link between service quality and behavioural intentions may not be as important as the indirect effect through customer satisfaction. However, consumers’ decision-making process relating to their purchases of services is usually complex. Thus, although the emotion-arousal opportunities through service employees are less in the service factory setting, there are still other sources of emotion arousals (that enhance customer satisfaction) that may be obtained from the effects from other non-employee based sources.

If the mediating effect is significant, an additional issue is whether the direct effect of service quality on behavioural intentions (i.e. SQ ! BI) is statistically significant when SQ ! SAT ! BI is also simultaneously examined in the same conceptual model. This leads us to our second proposition: P2. Both the direct effect (i.e. SQ ! BI) and the indirect effect (i.e. SQ ! SAT ! BI) of service quality will provide a good explanation of customers’ behavioural intentions in the context of the service factory.

Laing et al. (2002) suggests that two elements may be regarded as critical foundations of services marketing and its development. In this interaction the concept of the service encounter is the focal point of marketing activity, representing a dyadic interaction between the customer and the provider. Service quality can be understood as how best an organization conforms to the requirements of its customers, and satisfies them in various aspects of the delivery of a service (Chakrabarty, 2006). Service encounter are therefore the point at which customers actually experience marketing orientation. So Market orientation is very essential for measure quality of services in Health Care organization.

By the mid-1980s, the concept of a marketing orientation began to guide the thinking of many healthcare executives and researchers. Kotler and Clarke (1987) were the first
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Researchers to clearly define and operationalized the concept of marketing orientation in healthcare organizations.

1.12 The relative importance of Market Orientation and Service dimension in health care

Ensuring services benefit not only patients but also healthcare providers are important. Patients who perceive they are content with services are likely to exhibit favourable behavioural intentions that are beneficial to the healthcare provider’s long-term success. Zeithaml and Bitner (2000) described how customers express such intentions in positive ways:

1. Praising the firm;
2. Preferring the company over others;
3. Increasing their volume of purchases;
4. Agreeing to pay a price premium.

Retaining customers may be more profitable than attracting new ones. Clancy and Schulman (1994) calculated the cost of attracting new customers to be approximately five times that of keeping current customers happy. On the other hand, customer dissatisfaction may lead to unfavourable behavioural intentions such as negative word-of-mouth, doing less business or switching to alternative service providers.

Therefore, healthcare providers have much to gain if they can understand what patients expect since this assists them by serving their patients better and building long-term relationships. If a healthcare service provider is to maintain itself as a viable entity in today’s competitive market then great care must be taken to not only identify patients’ needs and wants but also ensure that these needs and wants are satisfactorily met. Human needs are states of felt deprivation such as physical needs for food, clothing and safety, social needs for belongingness and affection and individual needs for knowledge and self-expression. Wants are the form taken by human needs as they are shaped by culture and individual personality. Exactly what are consumers’ needs and wants in a healthcare context? By and large, healthcare can be considered “credence” good – an offering that consumers will never be able to evaluate owing to a lack of medical knowledge (Bloom and Reeve, 1990). Given healthcare’s credence, patients are likely to look for cues or “signals” that are redolent of
treatment quality they are likely to receive (or do receive) from a provider. Office aesthetics, staff appearance, relationship between patient and doctors and the punctuality of appointment among others may be medical care quality indicators. These service quality surrogate indicators can be used by patients to assess service provider efficaciousness. The most widely accepted measurement scale for service quality is SERVQUAL (Parasuraman et al., 1988), which consists of five essential service quality dimensions:

1. Tangibles;
2. Reliability;
3. Responsiveness;
4. Assurance;
5. Empathy.

Within each dimension there are several items (22 in total) measured on a seven-point scale from strongly agree to strongly disagree. Although SERVQUAL proved to be a robust service quality measure, it has been subject to criticisms conceptually and methodologically (Babakus and Mangold, 1989; Brown et al., 1993; Carman, 1990; Cronin and Taylor, 1992; Spreng and Singh, 1993; Teas, 1993a, 1993b). One of these criticisms is SERVQUAL’s inappropriateness as a generic measure for all service settings. There is research that service quality is contingent upon service type (Babakus and Mangold, 1989). Since SERVQUAL was generated outside healthcare and has limited examination in the healthcare literature, additional research is necessary to gauge its applicability to healthcare services. Specifically, there is a need to test if SERVQUAL is a comprehensive patient evaluation of healthcare service quality measure or if additional dimensions are needed.

In their popular measuring service quality framework, Parasuraman et al. (1988) used a single expectation standard, desired expectations as a comparison against which service performance is assessed. Recently, researchers proposed that multi-expectation standard approaches may be more appropriate for service quality models (Boulding et al., 1993; Zeithaml et al., 1993; Parasuraman et al., 1994). This model proposes that service expectations can be separated into an adequate standard and a desired standard (Zeithaml et al., 1993). Between these two expectation levels lies “tolerance zones” that represent a performance range consumers consider acceptable.
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While the literature concerning service quality dimensions in the healthcare industry is replete with studies from the developed world, researchers from developing countries have been exploring the applicability of the related models and frameworks in their specific context. This work is an effort to comprehend the major stakeholder perspectives germane to the delivery healthcare-related services in India. It attempts to throw light on the role played by the patients’ family members and friends (referred to as “attendants”) in the healthcare arena. In India, patients, in general, and in-patients in particular, are always accompanied by their family members or friends (or at least one of them), by volition provide necessary assistance to the patient for the entire duration of the stay in the hospital by staying in the same premises. Service quality research in the Indian healthcare context not only needs to take cognizance of the indispensable role played by attendants, but also examine their influence on patients’ satisfaction with the services offered by the hospital.

The Indian healthcare industry has been growing at a pace comparable with the Indian sunrise industries such as Telecom and Bio-technology. The developed world is also waking up to the reality that healthcare industries in developing countries such as India have come of age, and they can offer quality service at a competitive price (India Brand Equity Foundation, 2007). A research report by PricewaterhouseCoopers (2007) observed: “Healthcare is one of India’s largest sectors, in terms of revenue and employment, and the sector is expanding rapidly. Today the total value of the sector is more than $34 billion. This translates to $34 per capita, or roughly 6 per cent of GDP. By 2012, India’s healthcare sector is projected to grow to nearly $40 billion.”

Despite the giant steps taken by the Indian healthcare industry, there is a need for improvement in customer service. A recent report of Sahay (2008) stated that even though medical care provided by India’s private hospitals is of a very high standard, the customer service leaves a lot to be desired. Jain and Gupta (2004) opined: “Quality has come to be recognized as a strategic tool for attaining operational efficiency and improved business performance.” Further, service quality has become the greatest differentiator, the most powerful competitive weapon most service organizations possess (Berry et al., 1988). Arasli et al. (2008) also found that patients’ needs were not met with in public and private hospitals in Northern Cyprus. Sahay (2008) added that staff attitudes to patients and their families would determine a fair amount of patient reaction and our hospital services and hospitals have some way to go on this front. In this context, an understanding of the interplay between
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factors such as quality of healthcare services, its outcome and patient satisfaction have become invaluable inputs for designing, managing and benchmarking healthcare systems. Hence, it is necessary to conceptualize service quality in the healthcare context. The specific nature of healthcare services vis-a-vis other service industries such as banking, hospitality and tourism is duly reflected in terms of the following traits:

Service Strategy: As physical goods contain some elements of service and services contain some physical components, marketers think of offerings as ranging along a good-services continuum. Healthcare is the most intangible service because the consumer cannot sample it before purchase and cannot evaluate it after consumption. The medical care provided varies from patient to patient, right from diagnosis to response to the treatment. There are many health professionals involved for treating a single ailment with a great variation of care. Further, the demand for a healthcare service cannot be predicted, but the facilities (e.g. emergency rooms) have to be staffed and kept ready for patients’ use. The consumer is not always the decision maker because it is the physician who often recommends specific hospitals and therapists to the patients who mostly follow the advice. Prahalad and Ramaswamy (2003) traced the emergence of a new business model for providing personalized service in the context of health care industry. They demonstrated through some case studies that future practices of innovation would shift from products and services to experience environments, where companies as well as consumers co-create value unique to individual customers.

Disruptive technologies and business models: Christensen et al. (2000) asserted that healthcare sector should allow cheaper, simpler and more convenient technologies which focus on low-end customers to disrupt the existing ones aimed at profitable high-end market, in order to be more efficient and provide higher quality care to patients.

Critical nature of service: The whole focus of healthcare industry is patients’ well-being (both physical and mental). Patients are usually in a physical or a psychological discomfort when they consume health services. Further, due to high degree of intangibility involved in providing care and high professionalism (e.g. physician specialization, skills, etc.) demanded, healthcare services are difficult to evaluate. Customers in healthcare. Healthcare has numerous consumers: patients, who actually consume the service provided; physicians, who recommend healthcare providers for their patients; third-party payers, who dictate patients’ choice of hospitals by their substantial financial influence. Keeping pace with technological
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advances, there is a fundamental shift in healthcare consumerism – patients are becoming better informed, more involved in their own healthcare and more demanding.

Context of developing nations in India, patients, particularly in-patients, are mostly accompanied by a family member or a friend (named “attendant” in the context of this study). As patients are physically or psychologically ill, attendants influence patients in choosing the hospital service providers (Strasser et al., 1995). Hence, attendants play a crucial role in healthcare. A study of some mid western hospitals by Naidu and Narayana (1991) showed that only 20 percent of hospitals have a high degree of marketing orientation and that marketing orientation is positively associated with bed size for profit ownership, and occupancy rate. These researchers also concluded that a marketing orientation is critical to the success of hospitals in a competitive environment. Naidu, Kleimenhagen, and Pillari (1992) concluded from a survey of some hospitals that hospitals had made extensive progress in moving toward a marketing orientation as earlier defined by Kotler and Clarke (1987). These authors noted that marketing is effective in the healthcare industry and found that a high marketing orientation in hospitals is positively related to the existence of a marketing department, bed size, and competition in the area.

Raju, Lonial, and Gupta (1995) studied the relationship of hospital market orientation and performance. They found that different dimensions of market orientation are associated with specific measures of performance and responsiveness to customers.

K.W. Green, S. Chakrabarty and D. Whitten (2007) is probably among the first of its kind investigate the relationship between market orientation and service quality across a wide array of industries, and incorporate these constructs into the domain of organisational culture focused on customer care. Based upon the results of this study they conclude that adoption of a market orientation by service organisations will lead to improved service quality. Of the two market orientation dimensions measured, customer focus is the more powerful in terms of explaining variation in the service quality dimensions of Infrastructure, Personnel quality, Process of clinical care, Administrative procedures, Safety indicators, Corporate image, Social responsibility and Trustworthiness of the hospital. This study validates the extant research supporting the propositions that market orientation and service quality positively impact organisational performance.
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These examples suggest that market orientation focuses on assessing need of the customer, and then subsequently affecting organizational performance. However, despite numerous such examples, there seems to be lack of empirical investigation in literature regarding this assumed relationship between market orientation and service quality in health care.

A proper business process in health care would be to first do marketing orientation for determining consumer needs and then, marketing skills are used to determine what can be done to satisfy selected needs at a competitive advantage, and a service is designed and marketed to the segment whose needs have been targeted in health care.

In simple words, we are suggesting that it is the survival of the ‘fittest’ or rather the survival of organizational projects that introduction their success in the global marketplace by orienting themselves to what would ‘fit the customer needs’ and, thereafter, deliver quality services that meet those identified needs. The philosophy of quality as ‘conformance to requirements’ (Crosby, 1979) applies in the services sector. It is impossible to ‘conform to requirements’, unless the service-providing organization knows the customer requirements. Hence, organizations need to follow the maxim of ‘staying close to the customers’ (Peters and Waterman, 1982), in order to discover the requirements of the customers. Once the customer requirements are understood through effective market orientation, organizations must conform to the standards for ensuring the customer perceptions of high quality.

The need to have an organizational culture that incorporates this need for ‘practicality’ and ‘customer orientation’ (Hofstede et al., 1990; Hofstede, 1998) has always been stressed in the organizational culture literature. Customers perceive the quality of delivered services to be high when the services meet the customer requirements. We believe that this organizational culture of customer orientation involves: a market orientation that focuses on and assesses customer needs and enables customers to perceive a high service quality by meeting those needs in a ‘feel good’ manner.

The International Journal of Services and Standards has published various papers that provide examples indicating a strong relationship between market orientation towards customers’ needs and the service quality provided. For example, Lainema and Hilmola (2006) while discussing industrial training described how effective market orientation allowed companies to ensure that their new products more closely met customer desires and eventually led to increased volume for service providers.
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Additionally, Seetharaman, Sreenivasan and Murugeson (2006) described how electronic payments through Financial Electronic Data Interchange (FEDI) brought about huge savings via reduction in paper checks, time in processing and administration work, and have therefore been responsible for improving market transparency, accountability and the increase in customer service levels. Furthermore, Sohail and Al-Ghatani (2005) studied the development of King Fahd International Airport in Dammam, Saudi Arabia, and suggested that travellers’ evaluation of service quality is influenced by various factors that need to be taken into account to maintain the expected standards of service. In addition, Ahsan and Herath (2006) studied the software developed by a Sri Lankan firm that targets low-cost airlines in Europe, and described how this software is designed such that customer queues are reduced and therefore value is added to the service provided by the airlines. Hence, these examples suggest that market orientation focuses on assessing the needs of the customer, and then subsequently delivering high service quality. However, despite numerous such examples, there seems to be a lack of empirical investigation in the literature regarding this assumed relationship between market orientation and service quality in various industries. The primary purpose of our investigation is to assess the proposition that adoption of a market orientation strategy leads to improved service quality for multi specialty hospitals. Data related to market orientation and service quality will be collected from different customers of multi specialty hospitals. The MORTN scale (Deshpande and Farley, 1998) was used to measure market orientation, and developed scale by using SERQUAL was used to measure service quality.

In summary, we propose that adoption of a market orientation that allows organizations to stay close to their customers (Peters and Waterman, 1982) will result in improved perception or service quality by customers.