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AN INVESTIGATION OF THE MARKET ORIENTATION OF PRIVATE HOSPITALS IN TURKEY

Final Thesis

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CONTENTS **PAGE**

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ÖZET

Türkiye'deki özel hastanelerin pazarlama oryantasyonlu olup olmadıklarının belirlenmesi amacı ile planlanmış, Nisan 2006- Mayıs 2006 tarihleri arasında İstanbul il sınırları içinde bulunan 130 özel hastaneden, 2004 Sağlık Bakanlığı Yataklı Tedavi Kurumları İstatistik Yıllığı'na göre en fazla poliklinik yapmış ilk 15 özel hastanede yapılan bir araştırmadır.

Uygulanan anket, Naidu ve Narayana'nın 1991 yılında Journal of Health Care Marketing dergisinde yayımlanan makalede kullandıkları anket formunun Türkçe'ye çevrilmiş halidir. Veriler, bu anket aracılığı ile yüz yüze görüşme tekniği, faks ve elektronik posta yolu ile toplanmıştır. Anket 19 sorudan oluşmaktadır. Anketi dolduracak olan hastane yöneticisine anketi doldurmaya başlamadan önce konu ile ilgili gerekli bilgiler verilmiştir.

Uygulama sonucunda ankete katılan 15 hastaneden 3 tanesinde pazarlama departmanının olmadığı, pazarlama departmanı olan hastanelerde çalışan sayısın 6'yı geçmediği belirlendi**.**

Çalışmanın ikinci aşamasında çalışma için belirlenen 15 hastanenin internet sayfalarını ne kadar etkili kullandıkları incelenmek istenmiştir. Konu ile ilgili olarak bu hastanelere hastalık hakkında bilgi almaya yönelik bir elektronik posta atılmıştır. Alınan cevapların değerlendirilmesi neticesinde 15 hastaneden 3 tanesinin internet sayfasının olmadığı görülmüştür. Geri kalan 12 hastanenin 6 tanesi gönderilen elektronik postaya cevap vermemişlerdir. Cevap veren 6 hastanenin cevapları incelendiğinde ise 3 tane hastanenin tatmin edici cevaplar verdikleri gözlemlenmiştir. Diğer 3 hastanenin cevaplarının içerikleri hastaya hastalık hakkında bilgi vermekten çok hastayı hastaneye ve yönlendirici bilgiler içermekteydi. Hastane yöneticilerinin ankete verdikleri cevaplar neticesinde Türkiye'deki özel hastanelerin pazarlama oryantasyonunu tam olarak uygulayamadıkları sonucuna varılmıştır. Bu çalışma ile birlikte yapılan ikinci çalışma neticesinde hastanelerin internet teknolojisine uzak olduğu internet sayfalarında verilen posta adreslerinin düzenli olarak kontrol edilmediği ve bu sayfaları önemli görmedikleri sonucuna varılmıştır.

SUMMARY

The objective of this research is to identify the degree to which private hospitals in Turkey are marketing oriented. The research is based on the data generated from the fifteen private hospitals out of the 130 hospitals based in the Istanbul city region with the highest number of out patient according to the 2004 Annual Statistics of Ministry of Health. The research was conducted between April 2006 and May 2006.

The study consists of a translated version of the questionnaire used by Naidu and Narayana (1991, Journal of Health Care Marketing) and an inquiry via email from a prospective customer.

The questionnaire consist of 19 questions designed to identify activities correlated to market orientation. Results from the questionnaire, show three of the hospitals do not have a marketing department and none of the hospitals with a marketing department have more than six employees dedicated to marketing.

Responses to the email inquiry identify how efficient the hospitals were in responding to a marketing opportunity. Results from the email responses show that three of the hospitals do not have a web page with an email address for questions. Of the remaining twelve hospitals, six did not reply to the email. Three of the hospitals gave satisfactory feedback with required information and three hospitals gave unsatisfactory feedback including cursory responses without substative information.

Based on the feedback from the questionnaire and customer inquiry, it is concluded that the private hospitals in Turkey are not fully applying the market orientation. In addition to not prompting marketing as part of business through a dedicated department, hospitals are also missing specific opportunities to market to perspective customers.

FIGURES AND TABLES **PAGE**

1. INTRODUCTION

1.1 Purpose

Hospital marketing identifies markets, attracts sufficient resources, develops appropriate services, and communicates the availability of those services. The structure, tasks, and effectiveness of the marketing have been the subject of increased inquiry by researchers and practitioners alike. This study explains the role of the hospital marketing in a growing competitive health sector**.**

1.2 Methodology

The study consists of two parts a questionnaire to determined activities related to marketing orientation, and an email survey designed to measure the response to customer inquiry. Fifteen private hospitals in Istanbul were selected based on their status as the largest hospitals according to the number of out-patients. Before the sending the questionnaire, the researcher contacted each hospital and determined the person responsible for the marketing department and presented the questionnaire via email, fax, or face to face interview. Each questionnaire was scaled to obtain a quantitative measure of overall marketing orientations for each hospital. In addition, a prepared email was sent to each of the fifteen hospitals to examine the speed of the response to the customer inquiry and the content and the length of the response. The email was designed to be short and clearly understandable for respondents.

1.3 Sources of Data

Data was collected from the selected fifteen hospitals' marketing department's managers or qualified persons responsible from the marketing department. The number of patients in the hospital was the most important criteria in order to select the fifteen hospitals. When collecting data for the second part of the study, email was sent to the authorized departments of the select hospitals.

1.4 Benefits Expected from the Thesis

The role of marketing in a health care facility has been a focus of discussion during the past decade. Varied opinions have been expressed about the purpose and contribution of marketing within the health care industry. There are two expected benefits from the thesis: first determine the extent of marketing orientation in hospitals, and, second, relate the degree of marketing orientation to hospital characteristics.

1.5 Limitations of the Thesis

The study has several limitations. The study was conducted using data from hospitals in a single city limiting generalization to other cities. However, looking at the marketing orientation at two points in time is possible. Also, the survey instrument used to measure marketing orientation was adopted from previous researchers. Finally, study was conducted using data from only fifteen hospitals. There are a total of 1217 hospitals in Turkey of which 278 are private hospitals. In Istanbul, there are 130 private hospitals alone.

1.6 Structure of the Thesis

The thesis has six chapters. The first chapter is “Introduction” which gives a preview of the thesis. The second chapter is “Health Industry” which analyzes the health sector and private hospitals. The third chapter is “Marketing Concept” which analyzes what marketing is and how marketing orientation applies to the health sector. The fourth chapter is “Research Methodology” which explains the characteristics of the research. The fifth chapter is “Findings Analysis Interpretation” which shows and discusses the collected data. The final chapter of the thesis is “Conclusions” which shows the researcher’s opinions about the thesis and the collected data.

2. HEALTH INDUSTRY

2.0.0 Overview

Turkish people, throughout their history, have shown great respect for physicians and given paramount importance to the constant and proper fulfillment of health care services throughout the country. In particular, in the era of the Seljuk and Ottoman Empires, hospitals were established under the name of "şifaiye, bimarhane, darüşşifa, maristan" through the support of foundations. Each of these hospitals, in general, were formed as a complex of buildings called "külliye" consisting of a mosque, university (medrese), Turkish bath and cookhouse. The first hospital in Anatolia was founded in Mardin by Eminüddin from "Artukoğulları" family, 1108-1122 A.D. During the period of Seljuk Ruler Gıyaseddin Keyhüsrev, the medical school called "Darüşşifa ve Tıp Mektebi" was founded in Kayseri as required in the will of Gevher Nesibe Sultan in 1205. In the context

of developments and reformist movements in the 19th century, we witnessed the establishment of new hospitals and training of the physicians in line with the inception of modern medical education in 1827. At the beginning of the 20th century, Provincial Administrators founded country hospitals in various places in the country and the hospitals belonging to foreigners and minorities began offering their services. The Republican age introduced a new approach to the maintenance, improvement, and expansion of in-patient clinic services that was considered an obligatory task of governments. Due to legislative changes in social welfare laws, private hospitals have blossomed in Turkey. Within the last decade, an increasing number of private hospitals have been built. Here is a brief overview of the Healthcare Sector to illustrate the importance of marketing expenditure in private healthcare systems in the past.

2.1.0 Health

Health is viewed holistically as an interacting system with mental, emotional and physical components. We define health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1994) (153). We also consider health as a basic and dynamic force in our daily lives, influenced by our circumstances, beliefs, culture and social, economic and physical environments. Health is not only the most important necessity but also an obligation of human life.

2.2.0 Healthcare Services

Healthcare is the industry associated with the provision of medical care to the health of an individual (55). Health services in Turkey are provided mainly by the Ministry of Health (MoH), Social Insurance Organization (SSK), Universities, the Ministry of Defence, and private physicians, dentists, pharmacists, nurses and other health professionals. Other public and private hospitals also provide services, but their total capacity is low. The fragmented structure of the agencies which provide health care makes it difficult to ensure effective coordination and delivery of health services. The Ministry of Health is the major provider of primary and secondary health care and the only provider of preventive health

services. At the central level, MoH is responsible for the country's health policy and health services. At the provincial level, health directorates accountable to the provincial governors administer health services provided by MoH. The parliament is the ultimate legislative body and regulates the health care sector. The two main bodies responsible for planning the health care services are the State Planning Organization (SPO) and MoH. The role of SPO is to define the macro policies. Objectives, principles and policies in health system are determined regularly in "Five Year Development Plans". MoH develops operational plans regarding the provision of health care services. MoH is also responsible for the implementation of defined policies. In every province, there is a provincial health directorate which is responsible administratively to the governor of the province and technically to the Ministry of Health. Administrative responsibility mainly involves administration of personnel and estates management, whereas technical responsibility involves decisions concerning health care delivery, such as the scope and volume of services. The Ministry of Health appoints the provincial health directorate personnel with the approval of the Governor. The Ministry of Health operates an integrated model and provides primary, secondary, and tertiary care.

The healthcare sector has a very important financial impact on the national and global economy. In 2003, Turkey's total per capita expenditure on health care was $452 (6.6% of GDP), far behind developed countries. By comparison, the United States total health care spending per capita spending was $5,635 (15% of GDP), the largest spending as a percentage of GDP (110). Although there is a strong trend of privatization in Turkey's healthcare sector, 80.24% of total hospital bed capacity was still provided by government agencies in 2000 (140). Approximately 70% of the population has health coverage either directly or as a dependent. People cover their medical costs either through one of the three social security government schemes (Social Insurance Agency of Merchants (SSK), 33%; Artisans and the Self-Employed (Bag-Kur), 16%; the Government Employees' Retirement Fund (GERF), 18.5% or through private health insurance (141). Healthcare services include preventative care and treating acute illness. The Healthcare Sector employs 304,516 health care workers either directly or indirectly, or one out of every 64 wage earners in the Turkish labor force (136). Healthcare Services cover the various activities of caring for individual patients including preventative care and the care for acute illness.

The Ministry of Health and Social Welfare is responsible for the examination, diagnosis, cure and rehabilitation of the general public (141). However, other government ministries, state economic enterprises (most of which are to be shut down or privatized), medical schools and some private sector agencies, also perform these services. Healthcare Services can be categorized in three categories: Protective Healthcare Services, Medical Treatment Services, and Rehabilitative Healthcare Services (70).

2.2.1 Protective Healthcare Services

Protective Healthcare Services include activities that protect human health and prevent disease. There are two kinds of protective healthcare services: individual and environmental. Individual services include all of the activities to protect an individual's health provided by doctors and healthcare professionals. Environmental services include all of the activities to control the harmful effects to human health caused by physical, chemical, and biological factors in the environment (70).

2.2.2 Medical Treatment Services

Medical Treatment Services include all of the activities directed to cure people with acute illness. These services include three levels of care:

First-level services include home-health or outpatient treatment provided by medical institutions such as health centers, doctor's office, dispensaries, maternal and child health centers, and polyclinics. These types of healthcare centers provide preventative care and non-emergency services (70).

Second-level services include inpatient treatment provided by public and private hospitals for people with physical or mental disabilities (70).

Third-level services include medical services specialized by disease or age group such as mental disease hospitals, bone disease hospitals, or even pediatric hospitals (70).

University hospitals which use advanced knowledge and technology to cure disease provide second and third-level services (70).

2.2.3 Rehabilitative Healthcare Services

The UN Standard Rules define rehabilitation as "a process aimed at enabling a person with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychiatric and/or social functioning levels, thus providing them with the tools to change their lives towards a higher level of independence. Rehabilitation may include measures to provide and/or restore functions, or compensate for the loss or absence of a functional or functional limitation."

Rehabilitation and its services can have a significant impact on a person's attitude to their changed life. There are two types of rehabilitation: medical rehabilitation and social rehabilitation (70).

Medical rehabilitation fosters the development of scientific knowledge necessary to enhance the health, productivity, independence, and quality of life of persons with disabilities. This is accomplished by supporting research on enhancing the functioning of people with disabilities in daily life (70).

Social rehabilitation assists disabled people’s ability to adjust to living with a disability and the impact that the life change has on their hopes and dreams for the future. It is about enabling a person to engage in their world in a meaningful way (70).

2.2.4 Human Resources

The number of health service personnel in Turkey in 2000 is indicated in Table 2.1. Private sector employment in Turkey is very high for dentists, pharmacists and specialist doctors, while other health personnel are employed mostly in the public sector. Many specialist doctors have dual employment; they work part time in public hospitals and have their own private practice. As of 200, in Turkey, on average, there are 797 people per physician, 4,237 per dentist, 2,914 per pharmacist, 947 per nurse, 1,630 per midwife and 1,437 per health officer. The ratio of population to medical personnel varies greatly among regions. The eastern parts of the country and rural areas have fewer personnel in all categories per unit of population due to a geographic imbalance in distribution of health institutions, economical, socio-economical and regional conditions. A Personnel Directorate within the Ministry of Health carries out recruitment and placement of staff for all these facilities. Remuneration is done in accordance with the Law of Civil Servants, which establishes a pay scale based mainly on education, duration of public service, and job title. There are automatic cost-of-living raises during the year, but the basic salary is not supplemented by incentives for better performance. Public employees are granted lifetime employment. Individual hospitals or provincial health managers have little autonomy to recruit fire or administer their own staff.

Table 2.1 Human resources for health services, 2000 (140)

	PUBLIC						
Type of Personnel	**Total**	**MoH**	**SSK**	**University**	**Other**	**Private**	**Per/Popu**
Physician	85,117	42,820	8,112	17,346	5,304	11,535	797
• **Specialist**	38,064	13,837	4,801	8,586	2,175	8,665	1,781
• **Practitioner**	47,053	28,983	3,311	8,760	3,129	2,870	1,441
Dentist	16,002	2,423	583	863	741	11,392	4,237
Pharmacist	23,266	793	864	621	240	20,748	2,914
Health Officer	46,528	33,708	3,059	3,347	2,880	3,534	1,457
Nurse	71,612	43,694	8,489	10,399	4,543	4,487	947
Midwife	41,590	38,674	1524	110	156	1,126	1,630

2.3.0 Healthcare Delivery System

Primary Healthcare

Since the law on socialization of health services enacted in 1961, the government has committed to a program of nationalization of public health services with the main objectives of providing primary care in rural areas and providing both preventive and curative services. The basic healthcare units are health centers and health posts at the village level. According to the current legislation, health posts staffed by a midwife serve a population of 1.000 – 2.000 in rural areas. As of 2001, there are 11,737 health posts in Turkey. Health centers serve a population of 5,000-10,000 and are staffed by a team consisting of physician, nurse, midwife, health technician, and medical secretary. The main functions of health centers are the prevention and treatment of communicable diseases; immunization; maternal and child health services, family planning; public health education; environmental health; patient care; and the collection of statistical data concerning health. There are 5,773 health centers as of 2001 in Turkey. Due to the priority given to certain programs especially in urban areas, there are 295 motherchild health/family (MCH/FP) planning centers, 273 tuberculosis dispensaries, 12 dermatology – venereal diseases dispensaries, 3 leprosy dispensaries, and 2 mental health dispensaries. These health facilities with their specialized personnel offer preventive and curative health services as well as training for health personnel working in other primary health care units. The services pertaining to protect public health and conducting laboratory based services are among the duties of MoH and have been carried out by the Refik Saydam Hygiene Center, which is an affiliate institution of the Ministry of Health. The Center also acts as the “Reference Center” of the provincial public health laboratories offering services all over the country.

Secondary and Tertiary Healthcare

MoH, the Ministry of Defence, the Ministry of Labor and Social Security, some State Economic Enterprises, Universities, and the private sector provide secondary and tertiary

health care services. Of the total of 1,240 hospitals, MoH runs 751. These provide 50.1 percent of the hospital beds in the country, with an average occupancy rate of 59.4 percent. SSK provides mainly curative services to its members in 118 hospitals with 28,517 beds (16.3 percent) and an occupancy rate of around 65 percent. The 43 university hospitals provide health services with 24.754 beds (14.1 percent) with an average occupancy rate of 61.7 percent. The Ministry of Health is the largest health services provider in Turkey, and employs 204,932 staff. The number of hospital beds per 10,000 populations in Turkey was 26 beds in 2001. A head medical doctor, together with an assisting hospital administrator administrates each Ministry of Health hospital and both are appointed by the Ministry of Health. Since the referral chain is not pursued properly, hospitals are usually used heavily as outpatient clinics.

Table 2.2 Bed distribution among institutions in Turkey, 2001 (140)

Institutions	**Number of Hospitals**	**Number of Beds**	**Beds (%)**
Ministry of Health	751	87,709	50.1
Ministry of Defense	42	15,900	9.1
SSK	118	28,517	16.3
State Economic Enterprises	8	1,607	0.9
Other Ministries	2	680	0.4
Universities	43	24,754	14,1
Municipalities	9	1,341	0.8
Associations	19	1,448	0.8
Foreigners	4	338	0.2
Minorities	5	934	0.5
Private	239	11,922	6.8
TOTAL	1,240	175,190	100.0

2.4.0 Healthcare Finance and Expenditure

In the period from 1980 to 2002, the ratio of the budget of the ministry of health to the budget of state fluctuated between 2.40% and 4.71%. In 1980, this ratio had been 4.21% and following a period of gradual increase, the share of the budget of the MoH reached its peak of 4.715 in 1992. However 1992 marked the beginning of a downward trend for the share of the budget of the MoH in the state budget. In 2002, the above mentioned share was 2.40%. On the other hand, the portion of the budget of the Ministry of Health in Gross National Product fluctuated between 0.38% and 0.91% throughout the same period. The funds derived from private and public sector sources are transferred to service providers through the Ministry of Health, the Ministry of Defense, social health security schemes,

Social Insurance Organization (SSK), the Government Employees Retirement Fund (Emekli Sandığı), the Social Insurance Agency of Merchants, Artisans and Self-Employed (Bağ-Kur), active civil servants, YÖK (university hospitals), state economic enterprises, municipalities, other public institutions and establishments, special funds, foundations, private health insurance companies, and, directly, by users in the form of out-of-pocket payments. Additionally, there is a large number of agencies involved in the finance of healthcare services and most of them also provision the service. This makes the structure of healthcare financing in Turkey quite complex.

2.4.1 Ministry of Health

The Ministry of Health accounts for the majority of Turkish healthcare expenditures. Approximately 34% (1.9 billion US $ in 1995) of the total healthcare expenditures is financed by Ministry of Health.

2.4.2 State Budget Allocations

The basic source of Health Ministry Hospitals is state budget allocations prepared through simple adjustments by taking the previous year's inflation rates into consideration. In recent years, inflation has presented a major challenge to efforts to control public

expenditure. It has, therefore, become routine to revise the initial general budget allocations during the financial year.

2.4.3 Direct payments by individuals to revolving funds of hospitals

Revolving fund revenues are basically fees paid for services by individuals or third party insurers. Fees paid for the health services are determined by a commission consisting of Ministry of Health and Ministry of Finance representatives without considering the actual cost of the services.

2.4.4 Special Funds

Since 1988, additional funding has been available from earmarked taxes on fuel, new car sales, and cigarettes. In 1992, hospital expenditures were 51% of total MoH expenditures and it increased to 51.4% in 1998. During the same period, the resources allocated for preventive health services gradually decreased from 7% to 3%. In 1992, the Ministry of Health started the Green Card implementation as inpatient care services and coverage for the operations services costs of citizens who are not covered by existing social health security schemes and unable to pay costs of health care services. From January 1992 to January 1997, the Green Card implementation included approximately 6.7 million people. Since the beginning of June 1997, approximately 385 million USD have been expent spent for inpatient care services of these citizens. During the period from 1923 to 2002, the share of the state budget allocated to the Ministry of Health fluctuated between 2.02% and 5.27%. In 1992, a downward trend began and the share fell from 4.71% in 1992 to 2.40% in 2002.

2.4.5 University Hospitals

University hospitals have two main funding sources: The state budget allocations and universities' revolving funds. The state budget covers both recurrent expenditure and

capital expenditure. Through rational pricing policies, the revolving fund revenues have been strengthened when compared to state hospitals. The expenditure of the university hospitals made through the revolving fund is controlled by the State Planning Organization

2.4.6 Social Health Security Schemes

Persons working under a service contract and their dependants, SSK, merchants, artisan and other self-employed persons and their dependants, Bağ-Kur, retired civil servants who worked according to Personnel Law No.657, persons retired from State Economic Enterprises, widow and orphan wage earners, their dependants, Emekli Sandığı, Active civil servants working according to Personnel Law No.657 and their dependants, by their institutions are covered by social health insurance.

2.4.7 Social Insurance Organization (SSK):

SSK is a social security organization for private sector employees, blue-collar public workers. It functions both as an insurer and as a health care provider. The members use SSK services but are referred when needed to MoH, University and private health institutions.

The SSK in general does not provide or pay for preventive services. SSK health services are funded through premiums paid by employees and employers. While a single system is used to collect both retirement and health insurance premiums, health premiums and health expenditure are identified separetely in the SSK accounts. There are two other sources of funding in addition to premiums: income from fees paid on behalf of non-members using SSK facilities (for example Bağ-Kur members), and income obtained through co-payments (10 percent for retired and 20 percent for active) of drug costs for outpatients.

Even though efforts are made so that the different insurance branches of SSK finance themselves, the branches having revenue surplus such as the health insurance branch

subsidized other SSK insurance branches such as retirement until 1994. General State budget transfers have been realized amounting to 2.662.1 million USD in 1999 and 656 million USD in 2000 to compensate for the loss of SSK. One of the major problems that SSK management faces today, is the over emphasis on cost containment policies at the expense of quality. Today most SSK users complain about the quality of healthcare and accessibility to SSK health facilities.

Furthermore there are private funds established in accordance with the provisional article 20 of the SSK Law. These funds are open to insurance, banking and stock market institutions and provide services to their members on at least the same level of autonomy in structure as permitted by the SSK Law. The generally used system is back payment of the expenses made by members. The users find the access to quality services being granted through these funds quite satisfactory.

2.4.8 The Social Insurance Agency of Merchants, Artisans and the Self-Employed (Bağ-Kur)

Bağ-Kur is the insurance scheme for the self-employed. All contributors have the same entitlement to benefits covering all outpatient and inpatient diagnosis and treatment. Bağ-Kur operates no health facilities of its own, but purchases the services by entering into contracts with public service providers. The scheme works as areimbursement system where fees are determined independently by the institution. Drug purchases require a 20 percent co-payment from active members and a 10 percent co-payment from retired members as in SSK.

2.4.9 Government Employees Retirement Fund (Emekli Sandığı)

The Government Employees Retirement Fund, primarily a pension fund for retired civil servants, also provides other benefits including health insurance. There is no specific health insurance premium collected from either active civil servants or pensioners. The scheme is basically financed by state budget allocations, which are a major component of

the Fund's general revenues. Government Employees Retirement Fund finances all health care needs of retired government employees with only a 10 percent drug co-payment paid by users. Government Employees Retirement Fund has no control over its rapidly growing health expenditures and basically pays invoices made out by the health facilities and pharmacies for its members. No technical analysis is done within the Fund about the service expenses or service utilization rates.

2.4.10 Active Civil Servants

Health care expenditure of all active civil servants is covered by their organizations through specific state budget allocations. When these are insufficient, new allocations are made.

2.4.11 Private Health Insurers in Turkey

In 2001 about 40 insurance companies were providing private health insurance, with a total coverage of 655.703 insured people and a total premium income of 188 million USD. A major prtion of the insured people are already insured by social insurance organisations and therefore pay the premium to the proper social institution, but get better service through their private insurance fund. Private health insurance is the country's fastest developing insurance branch.

2.5.0 Hospitals

Before the late 1980s, a few private hospitals, mainly in Istanbul, were established by ethnic minorities (such as Greeks and Armenians) and foreigners (Americans, the French, Italians, Bulgarians, and Germans). Private Turkish enterprises were limited to small clinics with fewer than 50 beds, often specializing in maternity care and functioning as operating theatres for private specialists. During the economic liberalization of the late 1980s, the government provided substantial incentives for investment in private hospitals.

A few initiatives took place in the early 1990s, and by the end of the decade over 100 new private hospitals had been established across the country, particularly in the larger cities. In contrast to the first generation of private hospitals established prior to liberalization, many of these new hospitals offer integrated diagnostic and outpatient services and luxurious inpatient hotel facilities to attract self paying, fee-for-service patients. According to the Ministry of Health, Turkey had 83 private hospitals in 1981 and 257 in 2001. Healthcare provided by private entities appears to be more responsive to demand. As a result, government agencies purchase some of their services from private hospitals. For example, the SSK already purchases cardiovascular surgical services from private hospitals and has recently decided to purchase other services, such as cataract surgery. Most private hospitals are located in cities with large populations such as Istanbul, Izmir and Ankara. However, they often build their facilities in less developed parts of these cities and provide an inexpensive and poor quality service. Some of these hospitals fail to meet the minimum requirements of the Ministry of Health, sacrificing quality for the sake of low prices, which suggests that the Ministry of Health does not manage its regulatory function well with respect to private hospitals. A recent development in the last ten years has been the establishment of private medical schools, which either have their own private hospitals or contract other private hospitals as teaching facilities. However, the quality of the training they provide and the value of this development have been questioned and are a matter of concern.

Hospitals are institutions comprising basic services and personnel – usually departments of medicine and surgery – that administer clinical and other services for specific diseases and conditions as well as emergency services. Hospitals may also provide outpatient services. They are equipped with inpatient facilities for 24-hour medical and nursing care, diagnosis, treatment and rehabilitation of the sick and injured, usually for both medical and surgical conditions (153). Hospitals employ, either directly or indirectly, the majority of the health sector labor force. According to a study by the Republic of Turkey Ministry of Health from 1992 until 1996, 93% of medical spending went to treatment services (64% outpatient treatment and 29% inpatient). The same study showed that hospital services accounted for 62% of the Ministry of Health spending (142).

2.5.1 Hospital Services

Hospital services include medical and surgical services and the supporting laboratories, equipment and personnel that make up the medical and surgical mission of a hospital or hospital system. Hospital services make up the core of a hospital's offerings. They are often shaped by the needs or wishes of the community to make the hospital a one-stop or core institution of the local medical network. Hospital services include a range of medical offerings from basic healthcare necessities or training and research for major medical school centers to services designed by an industry-owned network of health maintenance organizations (HMOs). The mix of services that a hospital offers depends almost entirely upon its basic mission(s) or objective(s). Hospital services define the core features of a hospital's organization. The range of services may be limited in specialty hospitals such as cardiovascular centers or cancer treatment centers, or very broad to meet the needs of the community or patient base, as in full service health maintenance organizations, rural charity centers, urban health centers, or medical research centers. The basic services that hospitals offer include disease control and prevention, diagnosis, and treatment, and research.

Disease Control and Prevention services are all the activities to protect human health by controlling health factors before they affect people.

Diagnosis is an art or act of recognizing the presence of disease from its signs or symptoms and deciding as to its character.

Treatment is medical care by procedures or applications that are intended to relieve illness or injury of sick people.

Research includes activities undertaken with the primary purpose of testing a hypothesis and permitting conclusions to be drawn with the intention of contributing to medical knowledge. Education includes the activities and strategies that teach people critical information about medical knowledge or skill.

2.5.2 The Rise of Private Hospitals in Turkey

Private hospitals started before the Turkish Republic. In the first years of the Turkish Republic, there were only three hospitals with a total bed capacity of 950. In the 1930s, private hospitals mainly managed and provided health services to foreigners and minorities. Since the law on socialization of health services enacted in 1961, the government has committed to a program of nationalization of public health services with the objective of providing primary care to rural areas and providing both preventive and curative services. From 1960 to 1970, private health service dominated private practice, radiology, and laboratory services (141). Since the 1980s, basic medical service providers like polyclinics and dispensaries have increased dramatically in cities and towns. Private healthcare blossomed between 1985 and 1990 in Turkey due to the long lines and impersonal service in state-run hospitals. In 1987, the Turkish Parliament passed the Law of Fundamentals of Health Services (Law 3359). According to this law, all public hospitals will be turned into Health Enterprises so that their resources could be utilized more efficiently improving the quality of the hospital services. In addition, these economic enterprises would be able to select or recruit their employees allowing the new organizations both administrative and financial freedom. In light of Law 3359, the autonomous decision-making structure and competition encourages the public hospitals to work efficiently and effectively in order to compete (141). Today, there are 240 hospitals with total 11,939 beds in Turkey. The Ministry of Health is the largest health service provider in Turkey. Out of 1,243 hospitals, the Ministry of Health runs 872 hospitals with 116,081 beds and occupancy rate of 60 percent (141). The management of public hospitals in Turkey is very centralized. As a result, public hospitals have been ineffective health service providers due to heavy bureaucratic pressure. Since 1992, considerable attention has been focused on healthcare in Turkey, with numerous claims and counter-claims about a crisis in the healthcare system. Politicians have called for reviews of health care issues and several task forces are looking at how to improve the national healthcare system of the country (141).

Since 1990, private hospitals have grown to fill the need left by the public hospitals. Most private hospitals have contracts with various insurance companies allowing patients to

receive better treatment. Private hospitals are preferred by patients of middle and upper classes. Despite the fact that state hospitals are sometimes better equipped than the some of private hospitals, many patients prefer going to a private hospital because of the personal and friendly care offered.

3. MARKETING CONCEPT

3.0.0 Overview

An examination of the literature indicates that both "marketing orientation" and "market orientation" have been used to describe the implementation of the marketing concept. Prior to the articles of Shapiro (1988) (129), Narver and Slater (1990) (105) and Kohli and Jaworski (1990) (73), authors of articles addressing the topic consistently referred to the "marketing concept" or "marketing orientation" in their writings. These 1990 articles, and later works by these authors, use the term "market orientation" as opposed to the more conventionally used "marketing orientation". In a more recent article by Slater and Narver (1995) (134), they state that they will follow the practice of Shapiro (1988) (129), Deshpande and Webster (1993) (40), and consider the terms market oriented, market driven, and customer focused to be synonymous. In another 1995 article (Hunt and Morgan 1995) (63), a distinction is drawn between the marketing concept and market orientation. There appears to be several related, but different constructs which marketing theorists have used to describe the way managers might orient their approach to a market. In an effort to establish a standardized nomenclature for future study, the following definitions are proposed.

3.1.0 Marketing Concept

The marketing concept had its formal articulation in the writings of McKitterick (1957) (93), Felton (1959) (44), and Keith (1960) (72), although earlier writings by Alderson (1955) (1), Drucker (1954) (42), and Converse and Heugy (1946) (24) stressed the need for

marketers to help their firms become customer centered. In fact, McKitterick mentions reading issues of the Journal of Marketing and Harvard Business Review of the 1930s and 1940s where the elements of the marketing concept were being discussed. Although the marketing concept has had its share of detractors (Bell and Emory 1971; Kaldor 1971; Groeneveld 1973; Sachs and Benson 1978; Hayes and Abernathy 1980; Riesz 1980; Bennett and Cooper 1981; Gordon 1986) (13,67,50,126,54,122,14,47), it had also had its defenders (Parasuraman 1981; Michaels 1982; Kiel 1984; Dickinson, Herbst, and O'Shaughnessy 1986; Houston 1986; Samli, Palda, Barker 1987; Hayes 1988; McGee and Spiro 1988; Webster 1988; Day 1992) (112,96,71,41,59,127,53,91,147,34) and has been referred to as arguably the most accepted general "paradigm" in the field of marketing (Arndt 1985) (6), and as "the most enduring tenet in the teaching of marketing" (Dickinson, Herbst, and O'Shaughnessy 1986) (41). The Commission on the Effectiveness of Research and Development for Marketing Management stated that the emergence and acceptance of the marketing concept had the single greatest impact on marketing management during the twenty-five year period from 1952-1977 (Myers, Massy, and Greyser 1980) (102).

Howard (1983) (60), in another attempt to define a marketing theory of the firm, uses a consumer behavior model to structure his theory, and reiterates the centrality of the customer philosophy aspect of the marketing concept as the focal point of his theory: "The central theoretical point here is that for a company to be successful, customers should be the dominant driving force". Leong (1985) (80), in his discussion of the sophisticated methodological falsification (SMF) philosophy of science approach to the study of marketing, commented that the SMF framework requires that the propositions/assumptions generally accepted within a discipline be defined. Citing Fern and Brown (1984) (45), Leong states that one means of determining what propositions have become generally accepted within a discipline is to see what "facts" have achieved "textbook status". That is, if marketing texts are according a proposition the status of being a "principle" for the discipline, then it can be considered as generally accepted within that discipline. The marketing concept certainly qualifies as a generally accepted proposition using this criterion. It is rare that a textbook on marketing management or principles of marketing is published today without a significant discussion in the first or second chapter on the

desirability for contemporary profit and/or non-profit organizations to have a “marketing orientation”, to be “market-driven”, or to “adopt the marketing concept”. Having a marketing orientation is said to be the hallmark of successful contemporary organizations, and numerous anecdotal cases of major organizations that have successfully adopted such a management orientation are cited as evidence of the necessity and value of becoming marketing oriented. The marketing concept is best thought of as a philosophy of doing business that can be the central ingredient of successful organizations’ culture (Houston 1986 (59); Wong and Saunders 1993 (152); Baker, Black and Hart 1994 (8); Hunt and Morgan 1995 (63)). “In other words, the marketing concept defines a distinct organizational culture that puts the customer in the center of the firm’s thinking about strategy and operations” (Deshpande and Webster 1989(39).

The term marketing must be understood not in the old sense of making a sale (selling) but rather in the new sense of satisfying customer needs. Marketing is a social and managerial process by which individuals and groups obtain what they need and want by creating and exchanging products and value with others. If we clarify this description, marketing is the business function that identifies customer needs and wants, determines which target markets the organization can best serve, designs appropriate products, services, and programs to serve these markets, and calls upon everyone in the organization to think and serve customers. Yet, many people see marketing narrowly as the art of finding clever ways to dispose of a company’s product. They see marketing only as advertising or selling. But real marketing does not involve the art of selling what you make as much as knowing what to make. Organizations gain market leadership by understanding consumer needs and finding solutions that satisfy these needs through product innovation, product quality, and customer service. If these are absent, no amount of advertising or selling can compensate. Marketing is too important to be left to the marketing department states David Packard of Hewlett-Packard. Professor Stephen Burnett of Northwestern adds in a truly great marketing organization, you cannot tell who’s in the marketing department. Everyone in the organization has to make decision based on the impact on the customer.

3.1.1 Marketing Concept for Healthcare Organizations

The importance of the concept of marketing may be best illustrated in its primacy as marketing theorists proposing the use of marketing principles for companies in industries where the application of marketing is relatively nascent. For example, consider the following quotes regarding the use of marketing for health care organizations, where marketing as a functional unit did not exist twenty years ago. “Perhaps the most important contribution marketing can make (to hospitals) is to infuse a management philosophy, a marketing orientation, throughout the operation” (Cavusgil 1986) (19). “Teaching market orientation throughout the (healthcare) organization may well be the core task of the marketer today.” (Parrington and Stone 1991) (115). The healthcare executive’s first responsibility is institutionalizing the market concept throughout the healthcare organization” (Rynne 1995) (125).

Almost three decades have passed since the first articles appeared urging the establishment of a formal marketing function in hospitals. Although an occasional article appeared before 1977, that year has been identified as “landmark” for hospital marketing (27), when a dramatic increase in articles about hospital marketing began to appear with titles like “Marketing - An Emerging Management Challenge” (77), “What Is Marketing” (149), “Concepts and Strategies for Health Marketers” (82), and “Introducing Marketing as a Planning and Management Tool” (144). Despite the belief that hospitals should adopt a marketing orientation (3,7,19,27,68,75,86,137), marketing has received less than unanimous and enthusiastic support by hospital administrators. The difficulties of implementing a marketing orientation in hospitals were evidenced almost immediately by articles with such titles as “Marketing Health Care: Problems in Implementation” (21), “Roadblocks to Hospital Marketing” (123), “Why Marketing Isn’t Working in the Health Care Arena” (109), “Market-place Language Harms Health Care” (52), and “Has Marketing Been Oversold to Hospital Administrator?” (78). This ambivalence about the appropriateness and effectiveness of marketing for hospitals has continued, with special sections in Hospitals (1986, 1987) (58), and Modern Healthcare (1987) (99) detailing the growing dissatisfaction of some hospital administrators with marketing, and articles by Clarke and Shyavitz (1987) (22) and McDevitt (1987) (90) questioning whether hospitals

had truly adopted a marketing orientation. More recently, Naidu and Narayana (1991) (103) studied the degree to which hospitals had become marketing oriented and concluded: "Our findings indicate that the health care industry, despite the competitive hardships during the past several years, has not embraced a marketing philosophy".

Toward the end of the twentieth century, hospitals had many challenges to increasing profitability, customer loyalty, quality of care, and market dominance. The marketing function, new to hospitals in the mid-1980s, was seen as a way to attract new customers, develop new services, and communicate "value" to potential buyers of its services. Adoption of a marketing orientation by hospitals was a necessary management strategy to achieve a competitive advantage in local markets. While intuitively appealing to many healthcare executives, the adoption of marketing by hospitals during the last two decades of the twentieth century was highly variable in part because of the perceived lack of relevance to hospitals operating in highly regulated, yet revenue-rich, environments of the 1970s and early 1980s (109,108). As these environments become more competitive and resource-limited following the implementation of Medicare's prospective payment system in the United States, marketing was vigorously advocated as a means for hospitals to achieve organizational objectives and a competitive advantage (3,22,75). Although many hospitals embraced marketing by the late 1980s, identifying the results of marketing efforts was difficult (22). In addition, Clarke and Shayavitz (1987) (22) reported continued confusion over the substance of hospital marketing – was it simply promotion and advertising or identifying and meeting customer needs?

3.2.0 Marketing Orientation Concept

While the marketing concept is considered a philosophy which can be a core part of a corporate culture, a marketing orientation is considered to be the implementation of the marketing concept (McCarthy and Perreault 1990) (87). This definition was accepted in Kohli and Jaworski's (1990) (73) major treatise on the marketing orientation construct when they said:

"In keeping with tradition (e.g., McCarthy and Perreault 1984) (87), we use the term market orientation to mean the implementation of the marketing concept."

Note that Kohli and Jaworski refer to the construct as "market" rather than "marketing". However they incorrectly reference McCarthy and Perreault who, in fact, use the term "marketing" orientation to refer to the implementation of the marketing concept. Thus, perhaps against Kohli and Jaworski's wishes, we will describe their discussion of the construct to be one of marketing (as opposed to market) orientation. This observation should not be thought of as an attempt to twist Kohli and Jaworski's words to fit our own purpose since it is clear from their definition of the construct that they are indeed referring to the implementation of the marketing concept as they previously indicated:

Market orientation is the organization-wide generation of market intelligence pertaining to current and future customer needs (i.e. customer philosophy), dissemination of the intelligence across departments (i.e. integrated marketing organization), and organization-wide responsiveness to it (i.e. goal attainment) (Kohli and Jaworski 1990) (73).

So, while the marketing concept is a way of thinking about the organization, its products, and its customers, a marketing orientation is doing those things necessary to put such a philosophy into practice.

In contrast to the marketing concept and its related construct marketing orientation, a market orientation involves a concern with both customers and competitors (Narver and Slater 1990 (105); Day and Nedungadi 1994 (36); Slater and Narver 1994 (133); Webster 1994 (148); Slater and Narver 1995 (134)). It has been distinguished from the other two constructs by Hunt and Morgan (1995) (63) who maintain that a market orientation; is not the same thing as, nor a different form of, nor the implementation of, the marketing concept. Rather, it would seem that a market orientation should be conceptualized as supplementary to the marketing concept. Specifically, researchers propose that a market orientation is;

1. The systematic gathering of information on customers and competitors, both present and potential
2. The systematic analysis of the information for the purpose of developing market knowledge
3. The systematic use of such knowledge to guide strategy recognition, understanding, creation, selection, implementation, and modification.

This definition most obviously distinguishes the market orientation from both the marketing concept and marketing orientation by what it adds (a focus on potential customers as well as present customers, and on competitors as well as customers) and subtract (an inter-functional coordination) from the other two constructs. This definition is consistent with the definition of the term "market driven" used by Day (Day 1984 (32); Day and Wensley 1988 (37); Day 1990 (33), 1992 (34), 1994 (35); Day and Nedungadi 1994 (36)). All three construct have been objects of a considerable and growing body of research devoted to determine the precedents, prevalence, and consequences of these important areas of concern.

It has often been assumed that market orientation is related to business performance. However, both market orientation and performance are multidimensional concept, and the strength of the relationship varies for different dimensions of performance.

3.2.1 Marketing Orientation for Healthcare Organizations

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) (75) were the first researchers to clearly define and operationalize the concept of marketing orientation in healthcare organizations. Their definition of marketing orientation states:

"That the main task of the organization is to determine the needs and wants of target markets and to satisfy them through the design, communication, pricing, and delivery of appropriate and competitively viable products and services."(75)

Because marketing focuses on promoting exchanges with target markets for the purpose of achieving organizational objectives, the adoption of a marketing orientation is seen as necessary to facilitate an organization's effectiveness (75). Effectiveness, according to Kotler and Clarke (75), is further reflected in the degree to which an organization exhibits five major attributes of a marketing orientation:

1. Customer philosophy: Are customers' needs and wants used in shaping the organization's plans and operations?
2. Integrated marketing organization: Does the organization conduct marketing analysis, planning, implementation, and control?
3. Marketing information: Does management receive the kind and quality of information needed to conduct effective marketing?
4. Strategic orientation: Does the organization implement strategies and plans for achieving its long-run objectives?
5. Operational efficiency: Are marketing activities carried out cost effectively?

A Journal of Health Care Marketing editorial titled "Is Marketing Really Sales?" (15) made the following observations on the current status of marketing and the marketing department in hospitals:

As the "marketing orientation" diffuses through an organization, what is the role of the central marketing department? As each clinician, billing clerk and receptionist understands the nature of a service business and develop a customer orientation, is the marketing department a redundancy? Few readers of this journal are likely to argue such a position. In fact, in more traditional industries, being market oriented does not mean the elimination of the marketing department, but most likely the enhancement of its power within the company. Health care cannot be said to follow the same trend.

What remains unclear is not only how marketing oriented hospitals should be, but also how marketing departments in hospitals should function to make certain that the appropriate degree of marketing orientation is enacted by the hospitals. If a marketing orientation is ever to permeate healthcare organizations, it will because the value of adopting a

marketing philosophy will become evident to key decision makers throughout the organization. Indeed, one of the clearest evidences that a strong marketing orientation operates within an organization is the pervasiveness of a marketing philosophy throughout line management, not just the marketing staff. Obtaining such a diffusion of marketing thinking among line management is not a problem with many product-producing organizations because, as Webster (1988) (147) noted, "In the most sophisticated marketing organizations (i.e., the consumer package goods firms primarily), marketing is the line management function and the marketing concept (a marketing orientation) is the dominant and pervasive management philosophy."

Marketing has become a key management function that is responsible for being an expert on the customer and keeping the rest of the network organization informed about the customer so that superior value is delivered. The shift from a transaction to a relationship focus has transformed customers into partners, and companies must make long term commitments to maintaining relationships through quality, service, and innovation. Consequently, market orientation has become a prerequisite to success and profitability for most firms.

To develop a market orientation that produces sustained viability, hospitals have to be effective in four areas: gathering and using information, improving customer satisfaction and reducing complaints, researching and responding to customer needs, and responding to competitors' actions. Hospital administrators should make sure all four of those dimensions are in place to improve the likelihood of long term success. How effectively their staffs execute those imperatives has a tremendous impact in how well hospitals perform in terms of financial success, market and product development, and internal quality. For hospitals, two of the four dimensions of market orientation relate to responsiveness. In the manufacturing sector, responsiveness is usually limited to the customers, be it the middleman to which the company sells or the consumer who is the end user. For hospitals, the term "customer" has a broader meaning and includes not only the patient but also physicians, insurance companies, and other groups. As a result, responsiveness to the customer and responsiveness to the competition are viewed as two distinct elements of market orientation.

While market orientation is assumed to affect performance, the concept of marketing orientation is not well understood, and several studies have attempted to shed light on it. But healthcare, and the hospital industry in particular, has not readily embraced the marketing philosophy. Many hospitals still do not have a marketing department and primarily rely on a combination of public relations and occasional advertising. But the industry is changing rapidly, and many hospitals, especially those located in competitive metropolitan areas, are making a concerted effort to apply the concepts and principles of marketing to their daily operations.

The present health care environment also has contributed to the importance accorded to market orientation. While competition from outpatient clinics and emergency centers is increasing, government support for hospitals is declining. With the added burden of increasing labor costs and the growing indigent population, tremendous pressure is being exerted on hospitals to find innovative ways to remain viable. The growing emphasis on service quality within the hospital industry also is placing a premium on marketing. In the process of improving service quality, hospitals are finding that obtaining input from the consumer, communicating with the consumer, and keeping the customer satisfied has a direct impact on the bottom line.

While researchers have explored the relationship between market orientation and selected aspects of hospital structure and hospital characteristics, few have examined the relationship between market orientation and performance in the hospital industry. In addition, the definition of performance in these studies usually has been limited to financial performance. The researcher, therefore, explored this relationship in this study by considering measures beyond financial performance.

Researchers have proposed varying definitions of market orientation in the literature. Market orientation has five major attributes, according to Philip Kotler and Roberta N. Clarke (75), who characterize firms possessing these attributes by their tendency to "determine the needs and wants of target markets and to satisfy them through the design, communication, pricing, and delivery of appropriate and competitively viable products and

services." The five major attributes of marketing orientation are customer philosophy, integrated marketing organization, adequate marketing information, strategic orientation, and operational efficiency.

According to John Narver and Stanley Slater (105), the desire to create superior value for customer and attain sustainable competitive advantage is the driving force behind market orientation. It consists of customer orientation, competitor orientation, and inter-functional coordination. The first two essentially involve obtaining and disseminating information about customers and competitors throughout the organization. Inter-functional coordination comprises the organization's coordinated efforts in order to create superior value for the customers, typically involving all major departments within the organization.

Ajay Kohli and Bernard Jaworski (73) suggest that intelligence generation, intelligence dissemination, and responsiveness are the three dimensions of market orientation. Market intelligence pertains to monitoring customer needs and preferences, but it also includes an analysis of how they might be affected by factors such as government regulation, technology, competitors, and other environmental forces. Environmental scanning activities are subsumed under market intelligence generation. Intelligence dissemination pertains to the communication and transfer of intelligence information to all departments and individuals within an organization through both formal and informal channels. And responsiveness is the action that is taken in response to the intelligence that is generated and disseminated. Unless an organization responds to information, nothing is accomplished.

3.3.0 Studies about Marketing Orientation in Hospitals

The above attributes have been used in a number of studies to measure the existence of a marketing orientation in hospitals and to measure the relationship of marketing orientation to other indicators of organizational performance. A study of 80 hospitals by McDevitt (1987) (90) concluded that larger hospitals have more of a marketing orientation; however, marketing orientation was not related to other operational characteristics such as

occupancy rates. McDevitt also found that the extent of marketing tasks completed in hospitals varied considerably among facilities in his study. A study of 153 Midwetern hospitals by Naidu and Narayana (1991) (103) showed that only 20 percent of hospitals have a high degree of marketing orientation and that marketing orientation is positively associated 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) (104) concluded from a survey of 176 hospitals that hospitals had made extensive progress in moving toward a marketing orientation as earlier defined by Kotler and Clarke (1987) (75). 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. Furthermore, these researchers suggested that a professional marketing director be appointed to lead the marketing function. In their study of marketing practices in multi-hospital system, Tucker, Zaremba, and Ogilvie (1992) (145) found that systems that were innovators, as compared to non-innovators, tended to use marketing information and formalized communications systems - key components of an integrated marketing information dimension of a marketing orientation. These researchers also found that innovative systems tend to have a broader scope of marketing activities than less-innovative systems.

Three studies have shown the relationship of a marketing orientation in hospitals to measure of hospital structure and performance. McDermott, Franzak, and Little (1993) (89) studied the existence of a marketing orientation in a national sample of 347 community acute care hospitals. Defining marketing orientation in terms of market intelligence activities, inter-functional coordination, and organizational responsiveness activities, they found that the adoption of a marketing orientation by hospitals is positively associated with financial performance. Naidu, Kleimenhagen, and Pillari (1993) (104) studied the adoption of product line management in 154 acute care hospitals. In this study, hospitals that use a product line management approach were found to have a high marketing orientation score. Raju, Lonial, and Gupta (1995) (120) 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 that responsiveness to customers and to the competition are most closely linked with financial performance of hospitals. Bhuian and Abdul-Gader (1997) (16) developed and tested a scale to measure hospital orientation by focusing on a range of marketing intelligence activities, which include many of the areas contained in Kotler and Clarke's (1987) (75) concept of marketing orientation. Using confirmatory and factor analysis, these researchers found their model to be helpful in explaining the marketing orientation of 237 not-for-profit hospitals. Laubeau and Jantzen (1998) (81), in American cross-sectional study of 235 acute care hospitals, found that marketing orientation is much higher among those hospitals that have strong affiliations with other providers. In addition, these researchers found that higher managed care penetration rates are related to lower marketing orientation scores.

3.4.0 Measuring Marketing Orientation

Empirical research investigating some aspect of the marketing concept and marketing orientation has been conducted over a period of more than 30 years. Appendix 1 represents a substantial number of the published studies in this field. In the table, "construct" refers to the name given to the construct by the researchers. While it is sometimes the operationalization of the construct as it has just been defined, that is not always the case. Sometimes the researchers have studied what may be best described as a hybrid version of the constructs as defined here. Hence, any effort to categorize the constructs investigated in these studies by applying the definitions proposed in this study would be frustrated by the fact that the original researchers might use one construct term to identify the object of study (e.g., marketing concept) while operationalizing a combination of the other two construct (e.g., market and marketing orientation). Therefore, it was decided to list the terms in Appendix 1 that the researchers themselves used to name their constructs. "Focus of measurement" identifies whether the researchers investigated the attitudes, behaviors or both. To be consistent with our definition of these constructs, the marketing concept (a philosophy) would involve a study of attitudes (e.g., has the philosophy been adopted by the firm's managers) and a market(ing) orientation would

require the measure of behaviors (e.g., what marketing practices indicative of the orientation have been implemented). Differences in the "object of measurement" are recorded as "subject" for those instances where the objective was to determine the degree of the construct present among the organizations studied, and "construct" when the objective was to develop a scale for the construct itself. This distinction will be expounded upon shortly.

Before the researcher addresses the measurement issues surrounding this body of research, several observations can be drawn from these studies. First, an examination of these studies reveals several categories of investigation:

1. Studies which report on the extent to which a type of firm or industry has adopted the marketing concept or become market(ing) oriented (Munsinger1964 (101); Hise 1965 (57); Barksdale and Darden 1971 (9); McNamara 1972 (94); Parasuraman 1983 (113); Dunn, Birley and Norburn 1986 (43); Greenley and Matcham 1986 (49); Peterson 1989 (117); Norburn, Birley, Dunn and Payne 1990 (107); Meziou 1991 (95)).
2. Studies which investigate the impact of a market(ing) orientation on some other function within the firm (Lawton and Parasuraman 1980 (79); Jaworski and Kohli 1993 (66)).
3. Studies which seek to distinguish between a market(ing) orientation and other orientations (Lusch and Laczniak 1987 (83); Morris and Paul 1987 (100); Miles and Arnold 1991 (97)).
4. Studies which explore the relationship between market(ing) orientation and some output or results measure such as profitability, customer satisfaction, or resource attraction (McCullough, Heng and Khem 1986 (88); Narver and Slater 1990 (105); Naidu and Narayana 1991 (103); Ruekert 1992 (124); Qureshi 1993 (119); Wong and Saunders 1993 (152); Day and Nedungadi 1994 (36); Pelham and Wilson 1996 (116)).
5. Studies which attempt to measure the future importance of the marketing concept (Lusch, Udell and Laczniak 1976 (85)).
6. Studies which seek to develop a scale for measuring market(ing) orientation itself (Decker 1985 (38); Whyte 1985 (150); Narver and Slater 1990 (105); Kohli, Jaworski and Kumar 1993 (74); Wrenn, LaTour and Calder 1994 (155); Wrenn 1996 (154)).

7. Studies which determine the moderating effects of environmental forces on market(ing) orientation's impact on performance (Jaworski and Kohli 1993 (66); Slater and Narver 1994 (133)).
8. Studies which investigate the different forms (as opposed to degree) of market orientation (Greenley 1995 (48)).

Secondly, a few general conclusions can be drawn from these studies regarding the value of adopting a market(ing) orientation:
1. Perhaps most significantly for marketing theorists and practitioners is the consistent finding that being market(ing) oriented does improve organizational performance. This has been shown to be true for large firms (Jaworski and Kohli 1993 (66); Day and Nedungadi 1994 (36)) as well as small (Pelham and Wilson 1996 (116)), product producers (Narver and Slater 1990 (105)), as well as service suppliers (Naidu and Narayana 1991 (103), for-profit (Slater and Narver 1994 (133)), as well as not-for-profit organizations (Wrenn, LaTour and Calder 1994 (155)), low tech (Decker 1985 (38)), as well as high tech (Ruekert 1992 (124)) firms.
2. Also of interest to proponents of the adoption of a market(ing) orientation are the recent findings that environmental conditions (market turbulence, competitive intensity, technological turbulence) do little to moderate the positive impact of market(ing) orientation on firm performance (Jaworski and Kohli 1993 (66); Slater and Narver 1994 (133)).
3. Adopting a market(ing) orientation can have significant internal benefits in addition to the external market performance benefits attributable to its adoption. Siguaw, Brown and Widing (1994) (132) report that if the firm is perceived as having a high market orientation, the sales force practices a greater customer orientation, has reduced role stress, and expresses greater job satisfaction and organizational commitment. Likewise, Jaworski and Kohli (1993) (66) discovered a significant positive relationship between a firm's marketing orientation and employee commitment to the firm.
4. Marketing orientation has also been found to be positively related to customer satisfaction (McCullough, Heng, and Khem 1986 (88)). However, more studies are needed to determine if this finding holds across industries.

The primary interest of our discussion of the marketing concept and market(ing) orientation construct is the measurement choices made by the researchers of the Appendix 1 studies. Before addressing the measurement issues involved in these studies researcher briefly discuss the theory of measurement. The researcher can then determine how this theory can be appropriately applied to the measurement of our constructs of interest.

Perhaps most influential in efforts to measure hospital marketing orientation has been Kotler's idea of a "marketing audit" (66). The approach is analogous to a financial audit: Auditors seek answers to questions such as, Are sales quotas set on a proper basis? or Is primary marketing research used to assist new product development? Answers are used to determine what the organization must do to become more marketing oriented.

Two of the best examples of the audit approach are studied by McKee, Varadarajan, and Vassar (1986) (92) and Naidu and Narayana (1991) (103). They are unique because they examined the predictive validity of a self-audit of marketing activities with respect to an objective organizational performance measure. McKee, Varadarajan, and Vassar (1986) (92) were able to explain nine percent of the variance in hospitals' occupancy rates using their audit-like measure of marketing planning orientation. Naidu and Narayana (1991) (103) also found a statistically significant relationship between their audit measure and occupancy rates but did not report the amount of variance explained. These results provide encouragement that being marketing oriented does make a positive difference for hospitals.

Ultimately, the audit approach does suffer from a serious flaw-arbitrary scoring systems are employed. For example, how is one to score having sales quotas versus using primary research to assist in service development? Indeed, this is a problem with all existing marketing-orientation scales - only the degree of performance of the behavior is scaled, not the value of the behavior itself. In reserarcher's view, it is critical to have experts place values on specific marketing behaviors because not all marketing-relevant behaviors are likely to be equal contributors to being truly marketing oriented. In addition, it is important to divorce the judgment of the value of the behavior from judgments about the occurrence of it. Individuals best able to judge the value of specific marketing behaviors

are not necessarily best able to judge their occurrence in an organization. What is needed at this point is an approach to measuring marketing orientation that incorporates the use of external expert judgment in determining the relevant marketing behaviors constituting a marketing orientation and the value of those behaviors for the organization, along with the use of internal key informants within a hospital to indicate which of those behaviors are in fact enacted by the hospital. A different internal key informant is also needed to indicate performance measure for the hospital. Specifically, the core idea of making expert judgments inherent in the audit approach can be developed into a more rigorous approach that avoids the deficiencies of the audit method. Such an approach may produce an instrument capable of explaining more of the variance in organizational performance than previous measures of marketing orientation.

The researcher begins by viewing marketing orientation as a behaviorally oriented, organization-level construct. By definition, the construct deals with the degree of implementation of the marketing concept by the hospital. The construct relates to actual hospital marketing behavior, not simply administrator's beliefs in or attitudes about the marketing concept.

The task is thus one of providing evidence both about the behaviors that are relevant to the construct and about their occurrence in the hospital. There are two types of potential evidence. First, it might be possible to obtain budgetary evidence. It would be simple to measure the extent to which the construct is manifested in the organization with such measures. However, the researcher views such an approach as problematic because such evidence would have to be interpreted. For example, expenditures for marketing research do not necessarily indicate a high degree of marketing orientation. One would have to consider the type of research and its use.

Attempts to measure market orientation at hospitals on the basis of customer philosophy, integrated marketing organization, adequate marketing information, strategic orientation, and operational efficiency have usually relied on one dimensional constructs and only a

single score. Some researchers have proposed that the concept can be measured more reliably with a multidimensional instrument.

One such effort produced a market orientation scale that includes six items for intelligence generation, five for dissemination, and nine for responsiveness. However, those results suggested that the dimensions of market orientation used may not be independent. Yet another study defined three sets of activities and, hence, three dimensions of market orientation: market intelligence, inter-functional coordination, and organizational responsiveness. Despite the variety of approaches, it has not been made clear whether any one measure is superior to the others.

Marketing scholars have long been calling for increased attention to be devoted to the development of measures of marketing constructs (Churchill 1979, Ray 1979) (20,121). This interest in the development of valid and reliable measures stems, to some degree, from the continued discussion of marketing as a science (Converse 1945; Alderson and Cox 1948; Vaile 1949; Bartels 1951; Hutchinson 1952; Baumol 1957; Buzzell 1963; Taylor 1965; Hunt 1976a, 1976b; O`Shaughnessy and Ryan 1979; Ingebrigtsen and Patterson 1986) (23,2,146,10,64,1,18,139,61,111,65) and the application of the scientific method to the study of marketing constructs (Zaltman, Pinson and Angelmar 1973; Anderson 1983, Hunt 1983; Arndt 1985) (156,4,62,6).

One of the reasons for the preoccupation with measurement is the desire to become more scientific, since it has been said that the progress and maturity of a science is judged by the extent to which it has succeeded in the development of measures for its constructs (Guilford 1954) (51). Without joining the debate about the nature of marketing as a science or scientific marketing, it is clear that if we are to heed the call to become more scientific in the development and testing of marketing theories, we must focus on developing quantifiable measurements of those theories' constructs. Marketing literature is rich with studies conducted with the intent of establishment a scale for measuring a marketing construct of interest and then subjecting the scale to a series of validity and reliability tests. (cf. Bruner and Hensel 1992; Bearden, Netemeyer, and Mobley 1993)

(17,12). Recent examples of such scales include the sexual identity scale (SIS) (Stern, Barak, and Gould 1987) (138), the consumer ethnocentrism scale (CETSCALE) (Shimp and Sharma 1987) (131), domain specific innovativeness scale (DSI) (Goldsmith and Hofacker 1991) (46), possession satisfaction index scale (PSI) (Scott and Lundstrom 1990) (128), purchase decision involvement scale (PDI) (Mittal 1989) (98), polychromic attitude index scale (PAI) (Kaufman, Lane, and Lindquist 1991) (69), sexual embeds in advertising (VASE scales) (Widing, Hoverstad, Coulter, and Brown 1991) (151), a scale to measure excellence in business (EXCEL) (Sharma, Netemeyer, and Mahajan 1990) (130), salesperson adaptive selling (ADAPTS) (Spiro and Weitz 1990) (135) and scales to measure service quality (SERVQUAL) (Parasuraman, Zeithaml and Berry 1988) (114), (SERVPERF) (Cronin and Taylor 1992) (30). Most recently, several marketing scholars have turned their attention to the study of market orientation - long considered a core construct in marketing (Kohli and Jaworski 1990; Narver and Slater 1990; Jaworski and Kohli 1993; Siguaw, Brown, and Widing 1994; Slater and Narver 1994, 1995) (73,105,66, 132,133,134). Attempts have been made to develop a scale for measuring the market orientation construct (e.g., the MARKOR scale of Kohli, Jaworski and Kumar 1993) (74). Since the purpose of measuring these constructs is to allow for their use in theory construction and testing, it is critical that the scaling of these constructs adhere to the "theory" of scale construction. Otherwise, we can have little faith in the measurement of these marketing constructs and, hence, little faith in the theories in which they are embedded.

4. RESEARCH METHODOLOGY

This thesis investigates the role of market orientation within the healthcare institutions in Turkey. Private hospitals were chosen under the theory that public and government hospitals are somewhat immune from competition; and therefore, less likely to have a marketing orientation.

A literature review of healthcare market orientation and past research provided a foundation for research utilizing. ProQuest 5000, Jstore, Elsevier Science Direct research databases from Dogus University and the Business Source Premier database from the Robert Gordon University. Additional research was done using the related theses in Marmara and Dogus Universities.

A thorough review of the literature led to a two part study: a questionnaire to identify activities supporting a market orientation and inquiry from potential customer to judge the responsiveness to a marketing opportunity.

The research is based on the data generated from the fifteen private hospitals out of 130 hospitals that are based in Istanbul which have the most number of out-patients according to the 2004 Annual Statistics of Ministry of Health. Istanbul has 50% of all hospitals in Turkey.

The questionnaire is a translated version of the questionnaire used by Naidu and Narayana in their article “How marketing oriented are hospitals in a declining market?” (1991, Journal of Health Care Marketing) To deliver the questionnaire, the hospitals were contacted to determine the proper person to respond. Then, the surveys were conducted via email, fax or personal interview.

The customer inquiry was conducted by investigating web pages for content and to identify email contact information. Then, email was sent requesting specific information to simulate interest from a potential customer. The responses to the email were analyzed for content and timeless of response.

5. FINDINGS ANALYSIS INTERPRETATION

Two different tools were used to in the study. First, a survey was sent to determine the extent to which the hospitals are marketing oriented. Second, an inquiry from a potential customer was sent via email to measure the hospital's response to a marketing opportunity.

1. Survey

The survey was started on April 28, 2006 and ended on May 28, 2006. All of the fifteen sampled hospitals completed the survey which have nineteen questions in full. The results of the survey are below.

1. Three of the responding hospitals do not have any marketing departments at all. Eight of them are simply relabeling their marketing departments as public relations, planning, and community relations departments. Only four hospitals have full marketing departments.

2. There are minimum of two and a maximum of six marketing professionals working in the marketing departments.

3. Ten of the participating hospitals reported that the top marketing executives seldom participated in the management decision process. That means marketing departments have no power to make decisions, but can only implement them. Two hospitals reported that the top marketing executives participated actively in the management decision process.

4. All of the participating hospitals reported that the overall skill level of marketing department/personnel in the areas of public relations, communications, marketing research, planning, sales, and advertising are fair to high.

5. Management at seven of the hospitals responded that their management philosophy in designing the hospital offerings is to serve a wide range of markets and needs with equal effectiveness.

6. Only five of the hospitals develop different marketing plans for different segments of the market. The rest only have one plan for the whole market.

7. Management at seven hospitals reported that their hospitals only concentrate on serving their immediate/current customers. They do not care about suppliers, delivery systems, competitors, customers, and environment.

8. Management at nine hospitals responded that there is formal integration and control of the major marketing functions but less than satisfactory coordination and cooperation.

9. Management at ten hospitals responded that marketing management work well with other management functions. The relationships are friendly although each department pretty much acts to serve its own power interest.

10. Management at ten hospitals responded that development of the new products and services are not well structured. Instead, they are planning according to collateral changes.

11. The survey shows that management does not perform sufficient marketing study such as image studies, survey of customer satisfaction, studies on hospital personnel, competitive analysis of other hospitals, feasibility studies for new products and services, studies on advertising effectiveness, and market analysis. Management teams need to improve their marketing studies. While three hospitals have not conducted any marketing studies, five hospitals conducted the last one more than three years ago.

12. Management at eight hospitals responded that management does not have enough knowledge about the potential and profitability of different marketing segments, customers, and product and services. Only three hospitals responded that they clearly and certainly understand the subject.

13. Management at twelve hospitals responded that little or no effort is expended to measure the cost effectiveness of different marketing expenditure.. Only three hospitals expend great effort to measure the cost effectiveness of different marketing expenditure.

14. Management at ten hospitals responded that their hospitals develops an annual marketing planning.

15. Management at twelve hospitals responded that the quality (quality, communication, innovativeness and information) of the current marketing strategy is not clear.

16. Management at eight hospitals responded that management does little or no contingency thinking.

17. Management at ten hospitals responded that the marketing expectations at the top are successfully communicated and implemented down the line.

18. Management at eleven hospitals management responded that the marketing resources are inadequate for the job to be done.

19. Management at eight hospitals responded that although management has installed systems yielding highly current information; management reaction times varies.

2. Email

Two issues appeared to be significant in analysing the extent to which the hospitals were marketing oriented and interested in building relationships with their potential customers:
1. Speed of the response to the customer inquiry
2. The content and the length of the message

50% of customers email inquiries sent have not been responded to at all by the private hospitals. The low level of response rate to the customer email inquiries clearly shows that hospitals operating in the Turkish domestic health service market lack of solid

understanding of marketing concept. It was also observed that the speed of limited responses to the customer queries were erratic. The time lapse between the sending of the inquiry and response varied between 48 hours and 100 hours for a particular hospital. Three of the hospitals do not have web sites and six of the hospitals, although they had web sites and their email addresses were provided in these web sites for their potential customers to contact, did not respond to any of the inquiries. The remaining six hospitals responded to inquiries. Responses of the hospitals were categorised according to the length and the content of the message as follows:

Table 5.1 Categories of responses to customer queries

Category / Grade	Explanation
0	No response at all.
1	A short response (E.g. "please visit our web site")
2	A short response but providing a telephone number for the potential customer to ring for detailed information.
3	A full response containing a direct answer to the potential customer's inquiry; asking questions for further clarification; showing interest in the customer; providing telephone numbers for the customer to get in touch; asking the customer to provide a phone number so that the hospitals can contact the customer; and providing details about the web site/pointing out to links for the customer to view.

When the responses were analysed, it was noted that only 3 of the messages were more or less suitable for category 3 and 3 of the messages were more or less suitable for category 2 responses. The overall responses to the original and follow-up email queries and their categories appeared to be as follows:

Table 5.2 An Analysis of the Categories of Hospitals Responses Given to Potential Customers

Type of Response	Response	%	Average Response Time
Number of no (Grade 0) responses	6	50	No response
Number of Grade (1) responses	0	0	-
Number of Grade (2) responses	3	25	50 hours
Number of Grade (3) responses	3	25	75 hours
Total	12	100	63 hours

Maintaining ongoing contact with the target audience is essential to developing relationships with the target audience. The analysis and interpretation of the survey show that hospitals operating in the Turkish domestic health service market are not using their email facilities effectively in creating and building relationships with their potential customers. The results of this survey supports Arat (1998) who argued that in Turkey, businesses are increasingly establishing company web sites, mainly for prestige reasons without really being aware of their consequences. He warned that if these web sites are not regularly updated and maintained well, that eventually the Internet might have a negative influence on the reputation of these firms.

As mentioned above, the low level of response rate to customer email queries is also attributable to a lack of an understanding and awareness of the marketing concept among the hospitals operating in the Turkish domestic health service market.

In conclusion, domestic hospitals in Turkey are not using email effectively which is a powerful tool in developing relationships especially in the health service market effectively. The installation of a web site, email facilities, and other information technology tools do not appear to mean much unless the management of organization believes that these systems can be used to the advantage of the business.

6. CONCLUSIONS

Today, private hospitals are not paying close attention marketing orientations. According to our research, the fifteen largest (number of patients) private hospitals in Turkey are not focused on marketing. Their marketing activities are limited to public relations, customer service, advertising, and promotion. In this respect, Turkish private hospitals lag far behind private hospitals in developed countries. Due to a lack of marketing, Turkish hospitals are not fulfilling the needs of customers making it very hard to compete with the private hospitals in Europe or United States.

Fortunately, our research also shows that the management of most private hospitals understand the importance of marketing and the lack of real marketing departments in the healthcare sector. They also know that having marketing departments will be a key factor in creating the next generation of private hospitals in Turkey. The application of marketing tools and techniques to the healthcare industry provides new opportunities for hospital managers. As the supply of hospitals exceeds the demands for for their services, the hospitals that focus on incorporating marketing into their business models will be the winners in the private healthcare system.

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STUDIES MEASURING MARKET(ING) ORIENTATION/MARKETING CONCEPT (144)

	Munsinger (1964)	**Hise (1965)**	**Barksdale and Darden(1971)**	**McNamara (1972)**	**Lusch, Udell and Laczniak (1976)**	**Lawton and Parasuraman (1980)**	**Parasuraman (1983)**	**Decker (1985)**
Construct	Marketing Concept	Marketing Concept	Marketing Concept	Marketing Concept	Marketing Concept	Marketing Concept	Marketing Orientation	Marketing Orientation
Focus of Measurement	Attitudes& Behaviors	Behaviors	Attitudes	Behaviors	Attitudes	Attitudes& Behaviors	Attitudes& Behaviors	Behaviors
Object of Measurement	Subjects	Subjects	Subjects	Consrtucts& Subjects	Subjects	Subjects	Subjects	Subjects
Measures (Scales)	Categorical and Open-Ended	Categorical	Likert	Categorical for subjects; Arbitrary scalling for construct (Thurstone-type)	7-pt.Likert type	Likert, Categorical	Likert, Categorical	Thurstone-type based on Kotler (1977)
Empirical Setting	Industrial Organizations	Manufacturing firms	Business Executives and marketing educators	Consumer and industrial companies	Business Executives	Manufacturing firms	Industrial and consumer goods firms	University marketing agencies
Findings	High adoption and implementation of marketing concepts	High adoption of marketing concept	High belief in concept but low implementation	higher adoption and implementation by consumer goods firms	Marketing concept expected to be important in the future	Adoption of marketing concept does not influence new product planning	Industrial goods firms more marketing oriented than consumer goods firms	Agencies scoring highly on orientation reported greater financial success

STUDIES MEASURING MARKET(ING) ORIENTATION/MARKETING CONCEPT (144)

	Whyte (1985)	**Greenley and Matcham (1986)**	**McCullough, Heng and Khem (1986)**	**Dunn, Birley and Norburn (1986)**	**Lusch, and Laczniak (1987)**	**Morris and Paul (1987)**	**Peterson (1989)**	**Norburn, Birley Dunn and Payne (1990)**
Construct	Marketing Orientation	Marketing Effectiveness (Orientation)	Marketing Orientation	Marketing Effectiveness (Orientation)	Marketing Concept	Marketing Orientation	Marketing Concept	Marketing Effectiveness (Orientation)
Focus of Measurement	Attitudes	Behaviors	Attitudes & Behaviors	Behaviors	Attitudes	Behaviors	Attitudes	Behaviors
Object of Measurement	Subjects	Subjects	Subjects	Subjects	Construct and Subjects	Subjects	Subjects	Subjects
Measures (Scales)	Likert	Categorical	Thurstone-type based on Kotler (1977)	Thurstone-type based on Kotler (1977)	Likert	Categorical	Categorical	Likert-type modification of Thurstone-type based on Kotler (1977)
Empirical Setting	Community health centers	Companies marketing incoming tourism to Great Britain	Banks	Large and small manufacturing firms	Manufacturing firms	Manufacturing companies	Small Business	Manufacturing (?) firms in US, UK, Australis, New Zealand
Findings	Marketing orientation of agency directors measured	Low level of marketing orientation present in companies	More marketing oriented banks had higher levels of consumer satisfaction	Small firms are as marketing oriented as large firms	Marketing and stakeholder concepts and inseparable philosophies	Firms rating high on entrepreneurial orientation also rate high on marketing orientation	The marketing concept is part of operating philosophy of small business managers	Dissimilar market orientation exists among firms in four English speaking countries

STUDIES MEASURING MARKET(ING) ORIENTATION/MARKETING CONCEPT (144)

	Narver and Slater (1990)	**Naidu and Narayana (1991)**	**Miles and Arnold (1991)**	**Mezlou (1991)**	**Ruekert (1992)**	**Jaworski & Kohli (1993)**	**Kohli, Jaworski and Kumar (1993)**	**Qureshi (1993)**
Construct	Market Orientation	Marketing Orientation	Marketing Orientation	Marketing Concept	Market Orientation	Market Orientation	Market Orientation	Marketing Orientation
Focus of Measurement	Behaviors	Behaviors	Behaviors	Behaviors	Behaviors	Behaviors	Behaviors	Behaviors
Object of Measurement	Subjects and Construct	Subjects	Subjects	Subjects	Subjects	Subjects	Construct	Subjects
Measures (Scales)	7 pt. Likert-type	Categorical and Thurstone-type based on Kotler (1977)	Likert and Semantic Differential	Itemized responses (1=poor,4= excellent)	Likert	Likert	Likert	Thurstone-type based on Kotler (1977)
Empirical Setting	140 forest products SBU`s of a US corporation	Hospitals	Furniture Firms	Manufacturing Firms	5 SBU`s of large high-tech U.S. firm	MSI member companies and largest 1000 firms in US	MSI member companies and largest 1000 firms in US	Public and Private colleges and universities
Findings	For non-commodity businesses, relationship between market orientation and profitability is monotonic	Marketing orientation has a strong association with hospital occupancy ratees	Marketing orientation and entrepreneurial orientation are related, but different, constructs	Marketing concept has been adopted by small firms	M.O. positively related to org. perf., job satisfaction, commitment to org. and trust in management by employees	M.O. affects performance across environmental contexts	Development and testing of a scale to measure market orientation	Marketing oriented colleges more successfully attract resources

STUDIES MEASURING MARKET(ING) ORIENTATION/MARKETING CONCEPT (144)

	Wong & Saunders (1993)	**Slater and Narver (1994)**	**Siguaw,Brown and Widing (1994)**	**Wrenn, LaTour, and Calder (1994)**	**Day and Nedungadi (1994)**	**Greenley (1995)**	**Pelham and Wilson (1996)**	**Wrenn (1996)**
Construct	Marketing Orientation	Market Orientation	Market Orientation	Marketing Orientation	Market Driven (Market Orientation)	Market Orientation	Market Orientation	Marketing Orientation
Focus of Measurement	Attitudes & Behaviors	Behaviors	Attitudes & Behaviors	Behaviors	Behaviors	Attitudes & Behaviors	Attitudes & Behaviors	Behaviors
Object of Measurement	Subjects	Subjects	Subjects	Construct	Subjects	Subjects	Subjects	Construct and Subjects
Measures (Scales)	Likert-type bi-polar (Various pairs)	Likert	Likert	Thurstone	Categorical and itemized responses (small extent-very good extent)	7-pt. Likert-type bi-polar (1=not at all, 7=to an extreme degree)	7-pt. Likert-type bi-polar (various pairs)	Thurstone
Empirical Setting	90 British, U.S. and Japanese companies	SBU`s in forest product co. and diversified mmfging corp.	Companies involved in sale of document imaging supplies	Hospitals	190 large firms in U.S., Europe, Australia, N.Z.	1000 companies in United Kingdom	Small firms	Non-Profit Hospitals
Findings	Highest performing co`s strike a balance between marketing and product orientation	Being market-oriented is cost-effective in different environments	Market orientation influences salesperson customer orientation and job attitudes	Hospital CEO`s and marketing officers don`t agree on hospital`s degree of M.O.	Results suggest that market-driven businessess should outperform other firms	Five different forms of market orientation were identified	M.O. offers small firms a competitive advantage, better perfor., and relative product quality	All of the five components of M.O. must be developed for org. success, but customer philos. İs most important

APPENDIX 2

DOĞUŞ ÜNİVERSİTESİ
PAZARLAMA YÜKSEK LİSANS TEZ ÇALIŞMASI

KONU :

Türkiye'nin özel hastanelerindeki pazarlama departmanlarının oryantasyonlarının değerlendirilmesi ve Hastane pazarlaması konusunda mevcut durumun araştırılması.

HAZIRLAYAN :

M. Fatih OYUL.

ÖĞRETİM GÖREVLİSİ :

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AÇIKLAMA :

Türkiye'de gelişmekte olan sektörler içerisinde özel bir yapı ve hassasiyeti bulunan sağlık sektörünün; teknolojinin yanı sıra pazarlama konusunda da ilerlemesi büyük önem arz etmektedir.

Özel hastaneler bugün mevcut hasta potansiyeline tam olarak cevap verememekle birlikte her geçen gün hızla iyi uygulamaların yapıldığı ve hizmet kalitesi ile birlikte hizmet alanının da genişlediği bir yapıya doğru yönelmektedirler. Bunların içerisinde tek bir konu üzerinde yoğunlaşmak isteyen kurumların varlığı da kabul edilmekle birlikte genel sağlık hizmetlerinin çoğunluğunu bünyesinde barındırmaya çalışan kurumlar daha dinamik olmak zorundadırlar. Sağlık hizmetleri ile birlikte sigorta, turizm, ulaşım, vb. konulardaki gelişmeleri tüm dünya ile birlikte yürütmek onlar için iş tanımında yer alan birer ibare olmuştur.

Bu çalışma Türkiye'deki hasta potansiyeli en fazla olan özel hastaneler ile yapılan görüşmeler sonunda; sağlık sorunlarının hangi kalitede çözümlendiği, mevcut sağlık hizmet konumunun pazarlama yönünden gelişmesi gereken konular ile ilgili somut verilere ulaşılabilmesi ve içinde bulunduğumuz durumun daha iyi anlaşılabilmesi amacıyla hazırlanmaktadır. Yardımlarınız için teşekkür ederim.

Saygılarımla.
M. Fatih OYUL

PAZARLAMA ORYANTASYONU İLE İLGİLİ SORULAR

1. Hastanenizin bir pazarlama departmanı var mı ?(Departmanın adına bakmaksızın takip eden fonksiyonlardan bir veya daha fazlasını gerçekleştiren; Reklam, Müşteri İlişkileri, Pazar Araştırmaları, Yeni ürün/Servis Geliştirme, Yeni Hizmetler Geliştirme, v.b.)
   _____ Evet (Adı, eğer Pazarlamadan farklı ise_____)
   _____ Hayır

2. Pazarlama departmanında veya (1. soru da yazılan departmanda) kaç kişi (tam zamanlı olarak) çalışıyor?
   _____ Sadece bir
   _____ İki veya üç
   _____ Dört altı arası
   _____ Yedi ve daha fazlası

3. Pazarlama başkan yardımcısı, direktörü, müdürü, üst düzey yönetimsel kararların alınmasına katkıda bulunuyor mu?
   _____ Her zaman
   _____ Bazen
   _____ Ara sıra

4. Pazarlama departmanındaki personeli; halkla ilişkiler, iletişim, pazarlama araştırması, planlama, satış ve reklam alanlarındaki yeteneklerini nasıl değerlendirirsiniz? (Her satıra bir işaret koyunuz)

	Çok Yüksek	Yüksek	Orta	Düşük
Halkla İlişkiler				
İletişim				
Pazarlama Araştırması				
Planlama				
Satış				
Reklam				

5. Aşağıdakilerden hangisi hastane hizmetleri planlarını, seçilen pazarların ihtiyaçları ve isteklerine hizmet etmesi bakımından yönetim felsefesini en iyi açıklar? (Birini işaretleyiniz)
   _____ Bizim hastanemiz öncelikli olarak mevcut ve yeni hizmetleri her kim bu hizmetleri arayacaksa onlara sunmayı düşünür.
   _____ Bizim hastanemiz geniş kapsamlı pazarlara ve ihtiyaçlara eşit etkililikte hizmet etmeyi düşünür.
   _____ Bizim hastanemiz hastane için uzun zamanda gelişen ve kar potansiyeli olan iyi seçilmiş pazarların ihtiyaçlarına ve isteklerine hizmet etmeyi düşünür.

6. Hastaneniz pazarın farklı bölümleri için farklı pazarlama planları geliştirir mi? (Birini işaretleyiniz)
   _____ Hayır
   _____ Kısmen
   _____ Çoğunlukla

7. Hastaneniz operasyonlarını planlarken genel pazarlama sistemi görüşünü mü (Tedarikçiler, Dağıtım sistemleri, Rakipler, Müşteriler, Çevre) benimser? (Birini işaretleyiniz)
   _____ Hayır. Bizim hastanemiz mevcut/şu anki müşterilere hizmet etmek için konsantre olmuştur.
   _____ Kısmen. Bizim hastanemiz uzun dönemde dikkatini dağıtım sistemine çevirmiştir. Buna rağmen emeğinin tamamını acil/şu anki müşterilerine servis etmek için harcar.
   _____ Evet. Sistemin diğer bölümlerindeki değişimlerin hastane için yarattığı tehlikeleri ve fırsatları tanımak için bizim hastanemiz genel pazarlama sistemi görüşünü benimser.

8. Üst düzey (Üst yönetim) pazarlama bütünleşmesi ve ana pazarlama fonksiyonları kontrolü var mı? (Örneğin; yeni pazarların geliştirilmesi, yeni servisler, yeni dağıtım sistemleri, reklam v.b.) (Birini işaretleyiniz)
   _____ Hayır. Bu pazarlama fonksiyonları üst düzeyde bütünleşmemişlerdir ve bazı verimsiz anlaşmazlıklar vardır.
   _____ Kısmen. Ana pazarlama fonksiyonlarında resmi bütünleşme ve kontrol vardır fakat işbirliği ve koordinasyon tatmin edici düzeyin altındadır.
   _____ Evet. Ana pazarlama fonksiyonları etkili olarak bütünleşmiştir.

9. Pazarlama yönetimi diğer yönetim fonksiyonlarıyla iyi bir şekilde çalışır mı? (Örneğin; Personel, Finans, Hasta Bakımı v.b.) (Birini işaretleyiniz)
   _____ Hayır. Pazarlama departmanının aşırı talepleri ve maliyetlerini diğer departmanların üzerine atması ile ilgili bir çok şikayet vardır.
   _____ Kısmen. İlişkiler dostanedir. Buna rağmen her departman kendinin güçlü menfaatlerine hizmet etmek için çalışır.
   _____ Evet. Departmanlar verimli bir şekilde işbirliği yaparlar ve sorunları hastanenin genel menfaati açısından olabilecek en iyi neticeyle çözerler.

10. Yeni ürün ve servis geliştirilmesi sizin hastanenizde ne kadar iyi organize edilmiştir?
   _____ Sistem hastalıklı tanımlanmıştır ve zayıf bir şekilde ele alınmıştır.
   _____ Sistem resmi olarak vardır fakat uygulama eksikliği vardır.
   _____ Sistem iyi yapılandırılmıştır ve profesyonellerce işletilmektedir.

11. En son ne zaman pazarlama çalışması yönettiniz? (Her satırda birini işaretleyiniz)

Pazarlama Çalışmaları	Üç yıldan fazla bir zaman önce	Bir üç yıl arası	Bir yıldan az bir zaman önce	Daha yönetmedim
İmaj çalışmaları				
Müşteri tatmini araştırması:Poliklinik hizmeti				
Müşteri tatmini araştırması:Yatan hasta hizmeti				
Hastane personeli çalışmaları (Doktorlar ve hemşireler)				
Rekabet analizleri diğer hastanelerle ilgili				
Uygulanabilirlik çalışmaları yeni ürünler, servisler ve pazarlar için				
Reklam etkililiği araştırmaları				
Bölgesel pazar analizleri				
Servis türlerine göre pazar analizleri				

12. Yönetim farklı pazar bölümleri, müşteriler ve ürünler/servislerin potansiyeli ve karlılığını ne kadar iyi biliyor?
   _____ Fazla değil
   _____ Kısmen
   _____ Çok iyi

13. Farklı pazarlama harcamalarının maliyet etkililiğini ölçmek için ne kadar çaba sarf ediyorsunuz?
   _____ Çok az veya hiç çaba
   _____ Az çaba
   _____ Büyük çaba

14. Pazarlama planınızın kapsamı nedir?
    _____ Bizim hastanemiz pazarlama planını çok az yapar veya hiç yapmaz.
    _____ Bizim hastanemiz yıllık pazarlama planı geliştirir.
    _____ Bizim hastanemiz detaylı yıllık pazarlama planı ve dikkatli hazırlanmış uzun kapsamlı planları geliştirir ve bunları yıllık olarak günceller.

15. Şu an ki pazarlama stratejisinin kalitesi (Açıklık, İletişim, Yenilikçi, Bilgi merkezli) nedir?
    _____ Şu anki strateji açık değil
    _____ Şu anki strateji açıktır ve geleneksel stratejinin devamı olarak gözükür.
    _____ Şu anki strateji açık, yenilikçi, veri merkezli, ve iyi sonuçlandırılmıştır.

16. Olasılık düşüncesinin ve planlamasının kapsamı nedir? (Çeşitli "eğer" sorularına gösterilecek alternatif reaksiyonlar)
    _____ Yönetim çok az olasılık düşüncesi üretir veya hiç üretmez.
    _____ Olasılık planlamasına nazaran yönetim daha çok olasılık düşünceleri geliştirir.
    _____ Yönetim resmi olarak en önemli olasılıkları belirler ve bunlarla ilgili olasılık planları geliştirir.

17. Yönetimin pazarlama planları, alt organizasyonlar tarafından ne kadar iyi yürütülebiliyor?
    _____ Kötü
    _____ Oldukça iyi
    _____ Başarılı

18. Yönetim pazarlama argümanlarını etkili bir şekilde uygulayabiliyor mu?
    _____ Hayır. Pazarlama argümanları daha etkili kullanılabilir.
    _____ Kısmen. Pazarlama konusunda gelişmemiz gereken noktalar mevcut..
    _____ Evet. Pazarlama argümanları profesyonel bir ekip tarafından son derece sistemli bir şekilde uygulanmaktadır.

19. Yönetim ani gelişmelere karşı çabuk ve etkili tepki verecek iyi bilgi sistemine sahip mi?
    _____ Hayır. Pazarlama bilgisi çok geçerli değil ve yönetim reaksiyon zamanı yavaştır.
    _____ Kısmen. Yönetim güncel pazar bilgilerini kısmen alır, yönetim reaksiyon zamanı değişkendir.
    _____ Evet. Yönetim yüksek oranda geçerli bilgileri veren sistemleri kurar ve hızlı reaksiyon zamanı vardır.

APPENDIX 3

EMAIL LETTER

Sayın Yetkili,

Yaklaşık iki seneden bu yana burnumdan kaynaklanan nedenlerden dolayı nefes alıp vermelerimde güçlük yaşamaktayım. Gittiğim bazı sağlık kurumlarının doktorları burnumda deviasyon olduğunu nefesimdeki problemlerin bu durumdan kaynaklandığını ve konu ile ilgili olarak bir ameliyat geçirmem gerektiğini bildirdiler.

Aşağıda yazacağım merak ettiğim sorularıma cevap verirseniz sevinirim. Şimdiden teşekkür eder çalışmalarınızda başarılar dilerim.

1. Bu ameliyat ve ameliyatı yapacak birim hakkında bilgi.
2. Ameliyatın maliyeti ve hastanede kalış süresi ile ilgili bilgi.
3. Bu ameliyat hastanenizde ne sıklıkla yapılıyor?
4. Ameliyatın riskleri nedir?
5. Ameliyatı yapacak kişilerin uzmanlık düzeyleri nedir?
6. Özel ve devlete ait sağlık sigortalarının hangileriyle anlaşmanız var?

Muharrem Fatih Yılmaz

Sayın Yetkili,

Ben 34 yaşında bir erkeğim ve iki gözümde de -4 derecelik Miyopi var. Bu rahatsızlıktan ötürü yaklaşık 16 senedir gözlük kullanmaktayım. Yaptığım bazı araştırmalar neticesinde bu konu ile ilgili bazı gelişmeler olduğunu öğrendim. Gittiğim bazı sağlık kurumlarının doktorları bu durumun düzeltilebileceğini ve bu operasyonun adınında Lazerle Görme Kusuru Düzeltme olduğunu söylediler.

Aşağıda yazacağım merak ettiğim sorularıma cevap verirseniz sevinirim. Şimdiden teşekkür eder çalışmalarınızda başarılar dilerim.

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2. Ameliyatın maliyeti ve hastanede kalış süresi ile ilgili bilgi.
3. Bu ameliyat hastanenizde ne sıklıkla yapılıyor?
4. Ameliyatın riskleri nedir?
5. Ameliyatı yapacak kişilerin uzmanlık düzeyleri nedir?
6. Özel ve devlete ait sağlık sigortalarının hangileriyle anlaşmanız var?

Muharrem Fatih Yılmaz

APPENDIX 4

			PRIVATE HOSPITALS			OTHER HOSPITALS		
	CITY NAME	POPULATION	Number	Number of Beds	Number of out-patients	Number	Number of Beds	Number of out-patients
1	ADANA	1.963.921	5	231	9.281	16	4.117	4.125.924
2	ADIYAMAN	665.571	0	0	0	7	619	933.396
3	A.KARAHISAR	832.153	1	50	32.058	17	1.839	1.650.911
4	AGRI	562.206	0	0	0	8	314	598.819
5	AMASYA	361.389	0	0	0	7	822	937.412
6	ANKARA	4.297.590	15	696	489.363	50	12.980	10.984.809
7	ANTALYA	1.974.022	10	415	121.589	18	2.744	4.413.990
8	ARTVIN	178.617	0	0	0	9	507	476.602
9	AYDIN	995.924	3	81	22.345	11	1.885	2.466.011
10	BALIKESIR	1.104.743	3	72	6.991	19	2.518	3.123.423
11	BILECIK	199.500	0	0	0	5	278	366.972
12	BINGOL	253.719	0	0	0	7	490	533.931
13	BITLIS	409.135	0	0	0	8	416	381.844
14	BOLU	269.365	0	0	0	8	966	719.795
15	BURDUR	253.025	0	0	0	5	586	668.954
16	BURSA	2.308.342	4	196	65.385	24	4.553	4.769.735
17	CANAKKALE	471.891	0	0	0	11	956	1.014.162
18	CANKIRI	274.185	1	0	0	7	440	426.185
19	CORUM	580.749	1	48	19.484	15	1.589	1.513.654
20	DENIZLI	871.140	4	141	31.909	13	1.492	2.371.342
21	DIYARBAKIR	1.465.255	2	35	18.668	9	2.764	2.088.203
22	EDIRNE	394.342	2	33	27.247	8	1.341	1.122.965
23	ELAZIG	597.626	1	22	3.643	10	2.250	1.343.604
24	ERZINCAN	317.841	0	0	0	10	621	710.004
25	ERZURUM	969.445	1	25	1.155	13	2.698	1.612.700
26	ESKISEHIR	723.579	2	35	44.099	12	2.693	1.978.522
27	GAZIANTEP	1.403.552	5	298	81.120	7	1.901	2.734.768
28	GIRESUN	525.941	0	0	0	12	1.281	1.221.485
29	GUMUSHANE	192.063	0	0	0	5	310	318.278
30	HAKKARI	261.335	1	0	0	3	187	281.273
31	HATAY	1.268.368	4	130	5.626	11	1.505	2.451.068
32	ISPARTA	542.441	0	0	0	13	2.200	1.448.914
33	MERSIN	1.826.043	5	230	114.884	11	2.781	3.492.371
34	ISTANBUL	11.184.865	130	6.200	3.333.978	66	21.884	17.981.775
35	IZMIR	3.652.092	15	851	309.092	35	9.168	8.954.966
36	KARS	307.581	0	0	0	5	353	392.643
37	KASTAMONU	348.019	1	29	12.965	15	1.153	962.208
38	KAYSERI	1.080.184	6	153	59.307	16	2.683	2.928.279
39	KIRKLARELI	331.391	1	22	7.620	8	676	1.043.650
40	KIRSEHIR	247.011	0	0	0	7	446	644.715
41	KOCAELI	1.314.510	6	122	94.058	14	1.890	3.072.724
42	KONYA	2.396.344	4	104	215.502	30	4.027	4.033.589
43	KUTAHYA	681.813	0	0	0	12	1.485	1.671.392

			PRIVATE HOSPITALS			OTHER HOSPITALS		
	CITY NAME	POPULATION	Number	Number of Beds	Number of out-patients	Number	Number of Beds	Number of out-patients
44	MALATYA	908.307	2	33	37.673	11	1.721	1.547.625
45	MANISA	1.286.949	4	128	50.892	22	2.802	3.502.368
46	K.MARAŞ	1.043.223	2	45	15.233	11	1.227	1.767.586
47	MARDIN	761.287	0	0	0	6	406	792.078
48	MUGLA	776.993	7	292	213.923	13	1.316	1.988.515
49	MUS	481.647	0	0	0	5	425	532.222
50	NEVSEHIR	313.866	1	25	19.565	6	376	573.600
51	NIGDE	363.554	0	0	0	8	681	775.747
52	ORDU	900.228	0	0	0	15	1.713	1.787.686
53	RIZE	367.346	0	0	0	7	860	1.237.260
54	SAKARYA	761.995	4	146	51.097	10	895	1.720.646
55	SAMSUN	1.201.743	2	49	26.742	17	3.648	3.211.932
56	SIIRT	269.993	0	0	0	6	300	327.859
57	SINOP	202.863	0	0	0	6	552	517.126
58	SIVAS	732.550	0	0	0	15	2.188	1.827.397
59	TEKIRDAG	689.283	6	171	82.147	11	1.114	1.562.408
60	TOKAT	864.334	0	0	0	13	1.437	1.665.488
61	TRABZON	1.047.710	1	67	4.440	16	2.534	2.293.494
62	TUNCELI	94.571	0	0	0	2	104	81.090
63	SANLIURFA	1.615.531	1	19	13.699	13	1.428	1.962.452
64	USAK	331.945	1	20	4.978	6	926	1.062.588
65	VAN	974.419	0	0	0	11	1.535	1.267.598
66	YOZGAT	719.474	0	0	0	11	892	975.385
67	ZONGULDAK	586.467	0	0	0	11	1.812	2.055.527
68	AKSARAY	425.570	0	0	0	10	664	720.089
69	BAYBURT	90.898	0	0	0	1	100	164.642
70	KARAMAN	252.235	0	0	0	4	373	433.747
71	KIRIKKALE	392.111	0	0	0	8	792	1.065.142
72	BATMAN	486.820	1	44	147.622	4	286	601.491
73	SIRNAK	390.892	0	0	0	5	170	219.668
74	BARTIN	170.646	0	0	0	4	386	511.498
75	ARDAHAN	133.686	0	0	0	3	140	134.622
76	IGDIR	177.803	0	0	0	3	90	202.340
77	YALOVA	181.260	0	0	0	2	366	532.097
78	KARABUK	212.039	1	53	21.827	6	682	817.871
79	KILIS	105.362	0	0	0	1	164	217.503
80	OSMANIYE	491.947	1	0	0	5	445	684.177
81	DUZCE	327.626	0	0	0	5	636	725.503
	GRAND SUMS	71.994.001	267	11.311	5.817.207	910	142.594	147.034.034

APPENDIX 5

No	NAME	Number of out-patients	Telephone No	Web Page
1	**Özel Acıbadem Hast**	260.743	0-216-544 44 44	www.acibademhastanesi.com.tr
2	**Özel Bayrampaşa Göz Merkezi**	116.895	0-212-612 79 20	www.gozvakfi.com
3	**Özel Amerikan Hast**	96.292	0-212-311 20 00	www.amerikanhastanesi.com.tr
4	**Özel Avcılar Hospital**	90.828	0-212-591 10 00	www.avcilarhospital.com
5	**Özel Memorial Hastanesi**	90.296	0-212-210 66 66	www.memorial.com.tr
6	**Özel İstanbul Medipol Hast**	81.164	0-216-327 39 19	www.medipol.com.tr
7	**Özel Türkiye Gazetesi Hast**	78.429	0-212-222 64 64	www.turkiyehastanesi.com
8	**Özel Universal Hospitals Group(Alman)**	73.974	0-216-326 06 55	www.almanhastanesi.com.tr
9	**Özel Şifa Hast**	61.928	0-216-390 92 43	www.pendiksifa.com.tr
10	**Özel Batı Bahat Hospital**	61.676	0-212-471 33 00	www.bahat.com.tr
11	**Özel İstanbul İnternational Hospital**	59.498	0-212-663 30 00	www.internationalhospital.com.tr
12	**Özel Safa Hast**	58.501	0-212-462 70 60	www.safahastanesi.com.tr
13	**Özel Medical Park Hospital**	57.505	0-212-531 13 13	www.medicalpark.com.tr
14	**Özel Avrasya Hast**	55.842	0-212-665 50 50	www.avrasyahospital.com
15	**Özel Göztepe Hast**	53.921	0-216-565 40 70	www.ogh.com.tr

9. CIRRICULUM VITAE

The researcher was born March 9, 1976 in Istanbul. He completed elementary, middle, and high school education in Istanbul. He graduated from Hacettepe University Business Administration Department in Ankara with a degree in Business Administration in June, 2000. He worked for an international drug company in Istanbul after completing his military obligation in July2001. In September, 2003 while working as a drug sales representative, he started studying at Doğuş University in order to obtain his master degree in Masters of Business Administration. He is single and has been working as a branch manager for an energy company based in Istanbul since February 2006.