Differences in Perceptions of Hospital Marketing Orientation between Administrators and Marketing Officers

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Summary

Hospital administrators have been struggling for more than a decade to determine the role and proper position for marketing and marketers within their organizations. Results of a study now confirm the expected—administrators and their chief marketing officers do not see the same marketing actions being conducted for their hospitals. The consequence of such perceptual differences in marketing orientation for the role of marketers within the hospital are significant and are discussed in this article. Of particular importance is the finding that the marketing behaviors of the organization as identified by line managers correlate strongly with both revenues (r = .64 for inpatient revenue) and occupancy levels (r = .44). Additionally, it was found that as little as a 10 percent improvement in a hospital's marketing orientation is associated with a $25 million increase in total net patient revenues and an 8 percentage point increase in occupancy rate.

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Roughly a decade and a half have passed since the first articles appeared urging the establishment of a formal marketing function in hospitals.[1] Despite the belief that hospitals should adopt a marketing orientation (Allen 1988; Arnold, Capella, and Sumrall 1987a, 1987b; Cavusgil 1986; Cooper 1985; Kaplan 1979; Kotler and Clarke 1987; Malhotra 1987; Stensrud and Arrington 1988), 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" (Clarke 1978), "Roadblocks to Hospital Marketing" (Robinson and Cooper 1980–1981), "Why Marketing Isn't Working in the Health Care Arena" (O'Conner 1982), "Marketplace Language Harms Health Care" (Hague 1979), and "Has Marketing Been Oversold to Hospital Administrators?" (Lamb and Finn 1982). This ambivalence about the appropriateness and effectiveness of marketing for hospitals has continued, with special sections in *Hospitals* (1986, 1987) and *Modern Healthcare* (1987) detailing the growing dissatisfaction of some hospital administrators with marketing, and articles by Clarke and Shyavitz (1987) and McDevitt (1987) questioning whether hospitals had truly adopted a marketing orientation. More recently, Naidu and Narayana (1991) 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."

A *Journal of Health Care Marketing* editorial titled "Is Marketing Really Sales?" (Berkowitz 1992) 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 develops 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 hospital.

If a marketing orientation is ever to permeate health care 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) 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."

Could it be that one of the problems with hospitals adopting a marketing orientation is grounded in the organization's structure that keeps marketing a staff function separate from line management (cf. LaTour, Calder, and Burns 1983)?

The objective of our research was to determine the degree of difference that exists between line administrators and chief marketing officers in hospitals regarding the extent of the hospital's marketing orientation. First, we discuss why there might be a difference of opinion between the CEO/COO and the marketing officer in the hospital regarding the degree of the hospital's marketing orientation. Then, we report on the results of a study exploring the differences between the line administrator and marketing officer's perceptions of the hospital's marketing activities (i.e., the hospital's marketing orientation). Finally, we discuss the implications of these findings for the role of marketing within hospitals.

Differences in Perspectives: CEOs/COOs and Marketing Officers

The previously cited ambivalence regarding the adoption of marketing practices by hospitals might be reflected in a difference of opinion between hospital marketers and line officers regarding what exactly is taking place in their hospital that constitutes "marketing behaviors." Some of the reluctance of hospital administrators to believe in the desirability of a marketing orientation for their hospital might be the result of misunderstanding what it means to be marketing oriented and the lack of evidence demonstrating the value of such an orientation. In some industries (e.g., consumer-packaged goods), a marketing orientation is so ingrained in management's culture that it goes unquestioned. In its more advanced stages, marketing orientation permeates general management thinking. According to Levitt (1960):

> The organization must learn to think of itself not as producing goods and services but as buying customers, and doing the things that will make people want to do business with it. And the chief executive himself [sic] has the inescapable responsibility for creating this environment, this viewpoint, this attitude, this aspiration.

However, few hospital administrators have completely accepted this responsibility for adopting the marketing orientation as the appropriate guiding philosophy for the organization (McDevitt and Shields 1985).

Brown (1983) has proposed five reasons to explain the problems associated with hospitals adopting a marketing orientation: (1) marketing is viewed and implemented too narrowly by health/medical services organizations and marketers; (2) most health/medical services marketers have little training or experience in marketing; (3) negativism and skepticism still surround the practice of marketing in some individuals' minds; (4) marketing has been both oversimplified and oversold in health/medical services organizations; and (5) marketing is not just the responsibility of individuals with a marketing title (yet it has not diffused throughout the hospital as a guiding philosophy).

It is possible that a given hospital might be more marketing oriented than its top administrator perceives. This would occur when marketing activities are being performed by employees who do not have marketing titles and the administrator sees marketing as being performed only by the functional department of marketing. This possibility illustrates the need to measure hospital marketing orientation as behavioral activity rather than as budgets, people employed in marketing, or other measures that are related to the marketing department alone. It is also possible that a hospital administrator may perceive the hospital's marketing orientation to be higher than average when it is, in fact, lower than average, because the administrator has an incomplete understanding of what constitutes a marketing orientation.

On the other hand, perhaps hospital administrators are good, objective observers of their hospital's marketing activities and that it is hospital marketers who are misperceiving the degree of marketing orientation present in the hospital. This might occur if the marketers incorrectly assume that what marketing actions they take in their staff function are widely recognized throughout the hospital. If marketing in some hospitals is "compartmentalized" and is seen as a function for marketing staff only and not as a hospitalwide activity (i.e., a marketing-oriented hospital in the truest sense would have integrated marketing orientation throughout all departments of the hospital), then we would expect to find a difference in the reported marketing orientation of the hospital according to marketing versus line administrators. One means of testing such an hypothesis is to measure a

hospital's marketing orientation according to the senior line officer and the marketing officer to determine if their observations converge or are substantially different from one another.

Measuring Hospital Marketing Orientation

Perhaps most influential in efforts to measure hospital marketing orientation has been Kotler's idea of a "marketing audit" (Kotler, Gregor, and Rogers 1977). 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 studies by McKee, Varadarajan, and Vassar (1986) and Naidu and Narayana (1991). 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) were able to explain 9 percent of the variance in hospitals' occupancy rates using their auditlike measure of marketing planning orientation. Naidu and Narayana (1991) also found a statistically significant relationship between their audit measure and occupancy rate 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 our 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 measures 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.

We begin 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, we view 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.

An alternative method of obtaining evidence, and one that explicitly recognizes the need for interpretation, is to use the judgments of experts. Two types of expertise are required for this task. One is familiarity with practices in a given industry that are most informative about marketing orientation (for making judgments about the *value* of behaviors). This is most likely to be obtained from prominent experts in the field of marketing who have wide exposure to the practices of the industry. The other is familiarity with a particular organization and knowledge of whether that particular organization engages in a given practice (for making judgments about the *occurrence* of behaviors). This is most likely to be obtained from those who have significant management responsibilities in the organization. We refer to developing evidence in this manner as the Hospital Marketing Orientation Scale approach.

Development of the Scale

The Thurstone (1959) scaling model provides an appropriate procedure for using expert judgments to measure the construct of marketing orientation. As a first step, it is necessary to generate a pool of item statements that capture the specified domain of marketing orientation. Following the suggestion by Arnold, Capella, and Sumrall (1987a) and, with significant modification, the measurement approach used by Naidu and Narayana (1991), Kotler's (1977) specification of the five elements of marketing orientation was used for further guidance. With some refinement, these elements are defined as follows.

1. *Customer philosophy*. To what extent do managers recognize the primacy of the market and gear up to offer superior value to chosen customer segments in terms of their needs and preferences?
2. *Adequate marketing information*. To what extent does management conduct studies of customers' perceptions, preferences, and buying habits? Is marketing research used to assist in service design, test price sensitivity, and assist in advertising design and evaluation?
3. *Strategic orientation*. How effective is management in designing marketing plans and tactics that can achieve organizational goals? Is competitor positioning and strategy considered in the process of strategy development?
4. *Operational efficiency*. To what extent are marketing plans implemented efficiently and the results monitored for rapid corrective action?
5. *Integrated marketing organization*. To what extent are the organization structure and coordination mechanisms and attitudes of other functional departments influenced by marketing thought?

Unlike Likert statements that express an extreme view and are scored on a "strongly agree" to "strongly disagree" scale, Thurstone-item statements are worded to fall at a specific point on the underlying continuum and are selected to represent a range of marketing practices across the continuum. An item pool was developed by reviewing the literature on marketing orientation and interviewing 18 marketing hospital industry experts (people who hold positions within the hospital industry such as corporate-level marketing directors, marketing vice presidents of hospitals, members of hospital marketing trade associations, presidents of hospitals, as well as prominent marketing consultants to the hospital industry, and marketing management scholars who study the hospital industry). Items were written to reflect hospital industry terminology. A total of 287 item statements were generated, covering the five areas of marketing orientation.

A panel of nine judges was asked to rate each item statement along a continuum anchored by the end-points, *primitive marketer* to *world-class marketer*. The construct being scaled concerns a stimulus that requires judges who have considerable knowledge of the range of hospital marketing practices to be able to locate items along the *primitive* to *world-class marketer* continuum. Consequently, judges were selected from among health care marketing consultants, academicians researching health care marketing, and officers of hospital industry trade associations who would have had a wide exposure to the range of hospital marketing practices and know the state

of the art in hospital marketing. For example, the statement "Our services are developed and modified with more consideration given to what we can do than to what the target market desires" received a median score of 2.25 (indicative of a relatively primitive marketer) by the expert panel. Table 1 contains additional examples of statements rated high and low by the judges for each of the five aspects of marketing orientation.

Obtaining Measures of Hospital Marketing Orientation

Selecting items for the questionnaire that would be sent to informants (hospital respondents) was based on the scale and reliability values calculated from the judges' responses. The objective in selecting items is to choose those items whose values are located at more or less equal intervals along the continuum and whose spread of ratings by the judges is relatively small and hence reliable. Item reliability is measured by the Q score or ambiguity value (Thurstone and Chave 1929). Low Q scores are desirable.

In keeping with Thurstone's original presentation of the equal-appearing interval method (Thurstone and Chave 1929), we selected 45 statements for

Table 1
Examples of Statements Indicating Low and High Levels of Marketing Orientation

Statements	Mean Judges' Rating
Customer philosophy	
1. My organization does not segment physician markets because we are trying to serve everyone.	1.12
2. The belief that we should be concerned with satisfying the needs of target markets permeates all levels of the hospital.	8.39
Adequate marketing information	
1. Marketing research has not been found to be needed or very useful.	1.25
2. Our marketing information system is well integrated with the hospital's management information system and patient records.	8.75
Strategic orientation	
1. Strategic market planning is initiated only under special circumstances such as when considering facility expansion or debt financing.	2.00
2. The marketing planning process leads to resource allocation decisions.	8.35
Operational efficiency	
1. We have not attempted to evaluate the results of our advertising.	3.14
2. Our marketing people attempt to demonstrate to top administration the returns the hospital gets for its marketing expenditures.	7.84
Integrated marketing organization	
1. Marketing enters the decision process late rather than early.	2.00
2. Marketing here is more than a staff function—it is heavily involved in line decision making.	8.35

Note: Scale ranges from 1 = primitive marketer, to 9 = world-class marketer.

the final scale. Nine statements were selected for each of the five aspects of marketing orientation in such a way as to be distributed across the 9-point scale continuum and to have the lowest Q values. While some have suggested (e.g., Edwards 1957) that a shorter set of 20 to 25 statements is adequate, it was felt that a large number of items was necessary to span the domain of the marketing-orientation construct.

The scale was administered to both line (the head administrator or chief operating officer) and marketing management (the vice president of marketing or equivalent) informants at 61 for-profit and nonprofit hospitals in seven corporate hospital systems. Additionally, the chief financial officer of each organization completed a questionnaire addressing performance measures such as revenues and occupancy rates. (Profits were not used as performance measures since many were nonprofit hospitals, and profits are more likely to be affected by a number of nonmarketing variables.)

Respondents were instructed to indicate whether their hospital engaged in the practices described in the listed statements. They were to check only statements that accurately reflected the *specific degree* to which that practice was engaged in by the hospital (i.e., they were not to check statements if their institution engaged in a specific behavior or practice to a greater or lesser degree than that indicated in the statement). For example, if, in response to "My organization does not segment physician markets because we are trying to serve everyone," a marketing or line officer indicated that his or her hospital *did* engage in this practice, then the value 1.12 contributed to the score "earned" by the hospital. The 1.12 represents the median scale value given this statement by the panel of hospital marketing expert judges. If the respondent indicated that the hospital engaged in the behavior "We segment our physician staff according to degrees of loyalty to the hospital," a 6.75 value was assigned. Of course, hospital respondents were not aware of the scale values attached to the 45 statements. They were asked only to indicate whether their hospital did or did not engage in the stated practice. A marketing orientation score was determined by calculating the mean score for the items marked by the respondent for each of the five subareas as well as for the entire questionnaire.

Results

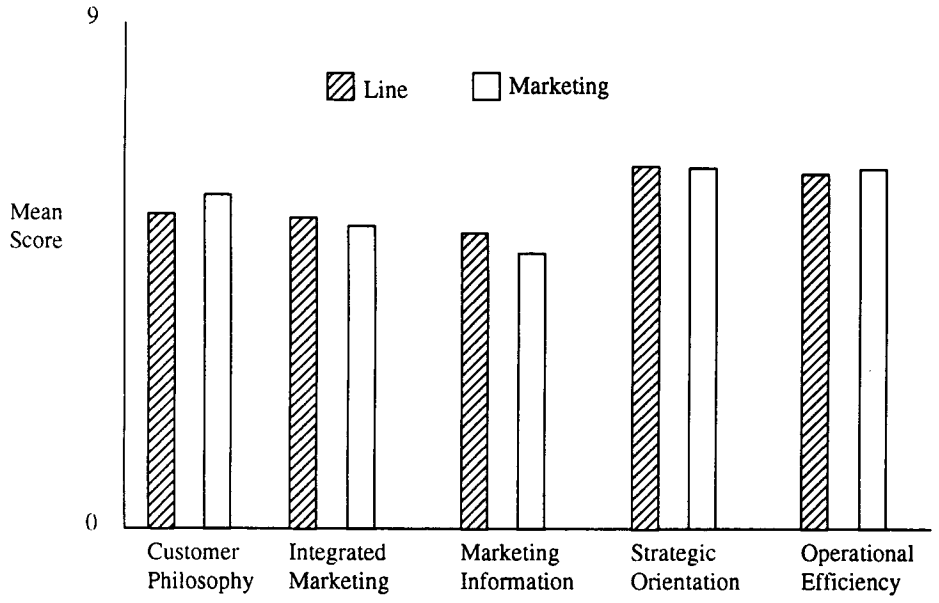
Table 2 shows the correlation in orientation scores for the two respondent groups. There is no significant agreement between CEOs/COOs and their chief marketing officers regarding the marketing behaviors being executed in their hospital. One might think that this low correlation is possibly a consequence of marketing respondents being more optimistic in identifying behaviors being conducted by the hospital that fall toward the higher end

of the scale. As can be seen in Figure 1, the average scores for line and marketing officers vary little among the five component areas. Statistical analysis of the means for the two types of respondents (Hotelling's T^2 and individual *t*-tests) shows that there is no difference between them. Another possible explanation might be that line respondents were more conservative than were marketing respondents in checking marketing behaviors that were performed in the hospital. This was found not to be the case as an average of 17.45 behaviors (out of the list of 45) were checked by line officers compared to the 17.52 average for marketers.

Table 2
Correlations of Line and Marketing Respondent Orientation Scores

Total Score	Customer Philosophy	Integrated Marketing	Adequate Marketing Information	Strategic Orientation	Operational Efficiency
r = .10 p = .286	r = .13 p = .249	r = −.03 p = .430	r = .18 p = .182	r = −.015 p = .470	r = .13 p = .243

Figure 1
Mean Scores for Line and Marketing Respondents for Marketing Orientation Areas



Thus there is no consistent bias in ratings such that marketers are either more or less optimistic than CEOs/COOs about the marketing behaviors enacted in the organization. What is happening is that in some organizations the marketer is reporting behaviors that reflect a higher degree of sophistication than that recognized by the CEO/COO, while in others the marketer is reporting behaviors that are less sophisticated than that recognized by the CEO/COO. In other words, on a hospital by hospital basis, CEOs/COOs and their marketing officers do not see the same marketing activities taking place (hence the low correlations in Table 2), but there is no consistent bias such that marketers generally report behaviors that are more or less marketing oriented (hence the lack of differences in the means of Figure 1). What this *does* mean is that within individual hospitals, there is disagreement between marketers and administrators—in some cases the marketer sees the institution as more marketing oriented than does the administrator and in others, sees the institution as less marketing-oriented. For example, in one hospital, the marketer sees behaviors that score a 6.5 on customer philosophy, while the administrator sees behaviors that score a 3.0. In another hospital, it is just the reverse; hence there is no difference in mean perceived customer philosophy between marketers and administrators and no correlation of their scores for this measure. This pattern is true for each of the five areas of marketing orientation.

At this point one might wonder if both are wrongly identifying marketing behaviors or whether one type of respondent is more correct in perceptions than the other. "Wrong" or "correct" in this case refers to the ability to identify marketing behaviors related to hospital performance. Previous research (McKee, Varadarajan, and Vassar 1986; Naidu, Kleimenhagen, and Pillari 1992; Naidu and Narayana 1991) has consistently demonstrated a positive relationship between hospital performance and a hospital's marketing orientation. Here, a "correct" identification by one of the respondent types would exist if their orientation scores were highly correlated with performance measures. We examined this possibility by correlating the marketing orientation scale scores with performance measures.

Table 3 results show a significant correlation between the line respondents' scores and performance measures (e.g., $r = .64$ for inpatient revenue) but no significant correlation for marketing respondents. The correlations for line respondents show an even stronger relationship between marketing orientation and performance than was previously found to exist. For example, the correlation of .44 between marketing orientation and staffed bed occupancy rates means that we can explain 19 percent of the variance in occupancy rates—twice as much as did McKee, Varadarajan, and Vassar (1986). Perhaps of greater significance is the finding that a roughly 10 percent improvement in marketing orientation is associated with a $25 million

increase in total net patient revenues and an 8 percentage point improvement in occupancy rates.

These findings give credence to hospital marketing proponents but further show that it is only when line officers indicate the presence of marketing actions that such actions relate to performance. Marketing activities reported by marketers have no significant relationship to hospital success. Thus, what is good news for marketing is not necessarily good news for marketers. We now discuss what implications these findings might have for the role of marketers in hospitals.

Implications

As previously noted by Webster (1988), in the most sophisticated marketing organizations there is little difference between the perceptions of line and marketing management with respect to marketing behaviors of the organization since marketing is the line management function. The separation of marketing and line management in and of itself does not mean, however, that there should automatically be a difference of the magnitude observed here. Why then do marketers and line managers in health care organizations have such differences of opinion concerning the marketing behavior of their institutions, and what does this imply about the role of marketing staff in the organization?

Perhaps the answer is at least in part due to the general type of organizational structure manifested in most health care organizations. Mintzberg (1979) refers to hospitals, universities, school systems, public accounting firms, social work agencies, and craft production firms as professional bureaucracies. Professional bureaucracies are characterized as having a production

Table 3
Correlations between Marketing and Line Respondent's Marketing Orientation Scores and Hospital Performance Measures

	Marketing Respondent Orientation Score			Line Respondent Orientation Score		
	r	r^2	p	r	r^2	p
Total inpatient revenues	.08	.006	.347	.64	.41	.001
Total outpatient revenues	.17	.029	.211	.65	.42	.001
Total net patient revenues (in and out)	.09	.008	.301	.58	.34	.001
Occupancy rates						
Licensed bed	.25	.063	.108	.41	.17	.009
Staffed bed	−.08	.006	.373	.44	.19	.015
Total patient days	.13	.017	.231	.49	.24	.007

core of professionals with a high degree of autonomy and power within the organization, and where control is based on both bureaucracy and clans (where clan control is the use of social characteristics such as values, commitment, traditions, and shared beliefs to control behavior). In none of these types of professional bureaucracies are marketers commonly functioning as line decision makers. It may be that professional bureaucracies by their very nature are not conducive to supporting a traditional, consumer products–like line management function for marketers.

The belief that hospitals are fundamentally different in function and structure from for-profit, product-producing consumer companies has existed for some time. Cavusgil (1986) has suggested that there has been an intuitive understanding that marketing, as structured and practiced in many other organizations, will not translate directly over to a hospital setting: "The belief persists that hospital markets are fundamentally different from other product/service markets and that conventional marketing approaches are therefore irrelevant for hospital managements."

Anderson's (1982) constituency-based theory of the firm may hold the explanation of why marketing has had such difficulty being integrated into hospital management as opposed to other industries.

Anderson (1982) suggests that marketing obtains influence within an organization to the degree that marketers have been successful in convincing other internal coalitions that satisfaction of customer needs ("effectively communicating the true meaning of the marketing concept") is a critical contingency in the organization's search for obtaining important, scarce resources from its environment. Furthermore, successful organizations will be characterized as having correctly identified the key resources needed for survival and will have adopted an orientation toward its environment that reflects such an identification by giving power to those subunits charged with negotiating exchanges with the key external coalitions. When customer satisfaction is seen as the key resource, successful firms will have adopted a *marketing orientation* toward the environment and given marketers power within the organization to negotiate exchanges with those external coalitions (patients, physicians, employers, etc.). Such power will be reflected in the ability of marketers to work with other organizational subunits to structure marketing programs designed with customer satisfaction in mind. Organizational objectives and goals will also reflect perception of the external constraints (desires of customers) and the imperative of structuring organizational activities to overcome those constraints (adoption of a marketing orientation). However, if other internal coalitions do not believe that customers constitute as critical a resource for the organization as do other external coalitions, then we would not expect to see the marketing subunit wielding as much influence in the organization or an absent or low-level

marketing orientation characterizing the organization's orientation toward its environment. In this case, another internal coalition seen as negotiating for more important resources with external coalitions would have more influence within the organization, and the organization's orientation, goals, and objectives would reflect this situation.

This line of argument is particularly convincing when we think of hospitals as professional bureaucracies with autonomous personnel controlled to a significant degree by clanlike systems. Here, the socio-political administrative realities preclude development of an organizationwide marketing orientation by administrative fiat and would instead occur only when other professionals see a marketing orientation as a critical contingency in the hospital's search for obtaining key resources from the environment. Kohli and Jaworksi (1990), in their review of the marketing-orientation construct, provided anecdotal support for the contingency theory's explanation of the difficulties of infusing a marketing orientation throughout the hospital-as-professional-bureaucracy when they reported:

> One health care administrator recounted that when the organization had begun to emphasize a market philosophy, it had started treating marketing personnel as the "blue-eyed boys" [sic] of the organization. Within a very short time, personnel in other departments began to resent this treatment and raised questions with the chief executive ("What are you doing for us?").

More anecdotal support exists in the general failure of hospital marketers imported from consumer-based industries to successfully make hospitals market-oriented. Here again, these failed marketers were coming from industries where marketers are often in line positions, and therefore the key internal coalition of marketing is seen as negotiating for important external resources.

To this point, we've discovered that a marketing orientation is positively related to performance, that CEOs/COOs and marketers do not see eye to eye regarding the hospital's level of marketing orientation, and that the hospital's socio-political realities may prevent marketers from operating as they would in other industries to overcome these differences between the line and staff officers. What then do these findings suggest should be the role of the marketing staff in hospitals? In seeking an answer to this question we must find a means by which marketers can help infuse a marketing orientation into the organization without alienating other key internal coalitions. That is, marketers need to make all people in the hospital, particularly line administrators, more familiar with and adept at implementing

marketing-oriented practices that do not appear to be *marketing* practices (i.e., an activity only in the domain of *marketers*). Cavusgil (1986) has said that "perhaps the most important contribution marketing can make [to hospitals] is to infuse a management philosophy, a marketing orientation throughout the operation."

Reviewing the descriptions of the five components of a marketing orientation, it is clear that there is nothing about the activities implicit in those descriptions that must be relegated solely to the purview of marketers. Indeed, it is an inherent trait of marketing-oriented organizations that key decision makers and workers "on the firing line" without marketing titles think and act in ways consistent with a marketing-oriented philosophy.

We hasten to add at this point that being marketing oriented does not mean becoming a marketer. However, it does mean being *market-driven*. According to Walker and Reukert (1987), this distinction is important:

> We believe organizations should *always* be market driven in the sense of being responsive to customer needs, but individual business units should not always be "market*ing* driven" in the sense of. . .primary control by marketing managers over strategic and operational decisions within the unit.

As previously discussed, the control by marketers described by Walker and Reukert (1987) is unlikely to occur in hospitals (at least not using the same organizational structure as in consumer goods organizations). Hospital marketers, then, must find ways of infusing a marketing orientation throughout the hospital by defining and training people to understand what it means to adopt a customer philosophy: obtaining, analyzing, and interpreting information concerning what the hospital's markets are saying about the services the hospital should effectively operate; assisting line officers in designing and implementing strategic plans that use such information and obtain competitive advantages for the hospital; monitoring performance and suggesting corrective actions where needed; and ensuring that such market-driven thinking is integrated throughout the organization.

Clearly, organizations with strong market orientations perform better in the marketplace. Now we need to start exploring ways in which health care organizations as professional bureaucracies peopled by a wide diversity of line and staff, professional and technical, and administrative and clerical workers can become more market-oriented. This will require us to find new organizational structures that accommodate marketers as functional specialists as well as create marketing-oriented decision makers throughout the organization.

Note

1. Although an occasional article appeared before 1977, that year has been identified as "landmark" for hospital marketing (Cooper and Kehoe 1978), when a dramatic increase in articles about hospital marketing began to appear with titles like "Marketing—An Emerging Management Challenge" (Lachner 1977), "What Is Marketing" (Wexler 1977), "Concepts and Strategies for Health Marketers" (Lovelock 1977), and "Introducing Marketing as a Planning and Management Tool" (Tucker 1977).

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