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CUSTOMER ORIENTATION OF THE HEALTHCARE INDUSTRY IN ALGERIA

Case Study: cmci of bousmail

Submitted by:

DJEBIRI Yasmine Asma

Supervised by:

Dr. Yahia Boukerch

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Dedication

Dear Mom and Dad

My beloved sisters Sarah and Loulou, and her kitty madjda

This work as well as the intention that pushed me to do it is dedicated to you

To my family who matters the most for me; and who supported me ever since I came to this world

Luv y'all

Thanks and gratitude

I would like to thank and express my high gratitude to every person, book, article, machine and every single thing that helped me to do this work and be the person I am now

As the prophet ‘may God’s peace be upon him’ once said: “who doesn’t thank people doesn’t thank God”

Special thanks to my parents whom I don’t know how to reward yet and my dear supervisor” best teacher I have ever had”, for helping and providing me with guidance a real support.

Myself too; the one who has been there for me ever since I can remember.

Summary

Pages

List of tables and figures

الملخص

الفكرة من جعل القطاع الصحي في الجزائر موجها للزبائن قد تبدو غريبة لبعض الأشخاص خاصة مع مجانية الخدمات التي يقدمها هذا الأخير لكن في ظل تطبيق بعض من أدوات التسويق (أساسيات العلاقة مع الزبون) خوصصة المستشفيات هي طريقة لتحسين إدراك الزبائن للنوعية و مفتاح لنجاح و ربحية القطاع على المدى الطويل

الكلمات المفتاحية

العلاقة مع الزبائن- إدراك النوعية- الخوصصة- التوجه نحو الزبائن- الربحية على المدى الطويل

Abstract

The idea of making the Algerian healthcare sector customer oriented might seem weird to some people especially with the actual system which assures the gratuity of the service; but with implementation of some marketing tools (customer relationship basics), corporatization of hospitals is a way to improve customer's quality perception and a key to the sector's success and long-run profitability

Keywords: customer relationship, quality perception, corporatization, customer orientation, long-run profitability.

Résumé:

L'idée de rendre le secteur de santé en Algérie orienté client peut paraitre bizarre à certaines personnes surtout avec le système actuel qui est gratuit, mais avec l'implémentation de quelques outils marketing (des basiques du marketing relationnel), la corporatisation des hôpitaux est façon d'améliorer la perception de la qualité auprès des clients et une clé de réussite du secteur ainsi que sa profitabilité sur le long terme.

Mots clés : relation client, perception de la qualité, corporatisation, orientation client, profitabilité sur le long terme.

Introduction

Introduction

I am a family-attached humanitarian person; constantly concerned with others' well-fare. My mother which whom I addressed as MAMA is my idol and the person about whom I care the most. I cannot withstand her suffering while there is much I can do so the main reason why I chose this topic is obviously clear enough

My mother's illness and the conditions in which patients are treated in Algeria are the primary reasons that directed me and aroused my interests in such a topic. In addition, Algeria spend roughly 13.29% of its annual governance budget on health care

Patients' dissatisfaction which is highly relevant to one of my specialty i.e. marketing …..

well this might not be all because I honestly feel trampled when I notice the leaks in GDP due to potential patients who'd rather travel abroad (neighbor countries) to treat basic health problems

According to the available documents and the acquired experience I saw how effective and profitable is health care sector once applying marketing in its different institutions and implement a customer centric health system instead of the status quo system.

Consumers are the only source of revenue to companies regardless their industry. Therefore, customer satisfaction is of immense importance and which out which there is no profitability. Moreover, a customer oriented company defines itself in terms of the customers it seeks to serve. Thus, a health care organization defines itself in terms of the patients it seeks to cure

Peter F. Drucker advanced the assertion that two functions drive a firm's performance, namely, marketing and innovation. To the best of my knowledge, Algerian health care organizations in the broadest sense of the term employ somehow advanced technology. However, marketing is entirely inexistent.

"No profitability, no customer satisfaction"

You will read beneath my intention to build a marketing plan that should be introduced to and implemented in a health care institution since we are a market oriented economy that encourages competition and claims that market is a battle realm and may the best win (market share maximization)

One of the maximization instruments is marketing which has become a milestone in companies no matter the sector where it kindles, nowadays nothing is for free that's why hospitals and clinics would better become health providing companies and become patient oriented

The main research question

With regard to a health care organization, public or private, what is the perception of marketing by the employees and how would the marketing mix be applied in said organization to make them customer oriented?

Sub questions

1/ would patients perceive marketing and show acceptability towards it if Algerian healthcare institutions would see flourishing days?

2/ confrontation between physicians and nurses with patients is inescapable; so do they have a marketing perception?

3/ assuming that simple employees would have to deal with patients; does this make them perceive marketing? And how?

4/the inexistence of healthcare marketing in Algeria conducts us to conceive marketing plan so what is the appropriate marketing mix of a health (service) provider?

5/Giving that most doctors have sworn the doctor's Hippocratic Oath, and from a marketing point of view this oath can be conceived as patient serving manual, do doctors abide or adhere to this oath in their practice?

Hypothesis

1/marketing will remain unknown regardless of the healthcare providers' competitive position

2/the Oath is slightly influencing the physicians and nurses marketing perception and attitude towards patients (rather call it ethics instead of marketing perception)

3/marketing and humanitarianism remain unknown for simple employees either for public or private sector

4/a copied American model would respond the Algerian healthcare market's needs

5/Doctors who have their own practice or affiliated with a private institution *do* abide by the Hippocratic Oath. Contrariwise, doctors whose practice is primarily in a public institution do not adhere to the said Oath.

Research plan

Chapter 1: contains 3 sections and will talk about the determinants of customer satisfaction, customer relationship marketing and the process of corporatization in the public sectors with some successful corporatization experiences in foreign countries

Chapter 2: entitled healthcare industry and its perspectives on economy in which we'll define the healthcare market and consumer's behavior in it besides the payer's mix to better know how to conduct the orientation thing

Chapter 3: this last chapter entitled theoretical marketing plan and strategy setting will bring up the hypocritical oath and the marketing plan "and was supposed to contain the practical part but due to the circumstances it was impossible for us to add it" in 3 seperated sections

Sampling design

In our study we will use a convenience sampling design because it's the one that suits our study the most

Ethical considerations

We will have to deal with people for sure (either healthcare practitioners, patients or maybe plain people in the street) and for some ethical considerations we shall absolutely not reveal the identity of anyone from the spoken about above person under any condition or reason

Chapter 01: customer satisfaction and its determinants

CHAPTER 1: Determinants of Customer satisfaction

The key to any company's success and long run competitiveness is customers' satisfaction with its products and services and 1977 was the year in which marketing started to be considered as a component of healthcare

In the early 80'sthe sector reached an important milestone thanks to retail-oriented activities such as health insurance, community service and pharmaceutical ones .to end up finally as a legitimate healthcare function

Customer satisfaction plays an important role within your business. Not only is it the leading indicator to measure customer loyalty, identify unhappy customers, reduce churn and increase revenue; it is also a key point of differentiation that helps you to attract new customers in competitive business environments

These are the reasons why we should focus on it to reach the goal of this research proposal which is how to customer orientate the healthcare institutions in Algeria?

Three different sections will bring up details of theoretical satisfaction determinants and how to make things work

Chapter 1: Determinants of Customer satisfaction

Section 1: generalities about customer satisfaction

Change is occurring at an accelerating rate; today is not like yesterday, and tomorrow will be different from today. Continuing today's strategy is risky; so is turning to a new strategy. Therefore, future successful companies specially the ones providing healthcare services will have to focus on the aspect of customer satisfaction

1-1/ definition of satisfaction

A psychological concept which is defined in different ways. Sometimes and as (KOTLER, 2000) states that satisfaction is considered as a judgment of individuals regarding any object or event after gathering some experience over time or person's feeling of pleasure or disappointment, which resulted from comparing a product's perceived performance or outcome against his/her expectations. According to some theorists, satisfaction is a cognitive response whereas some others consider satisfaction as emotional attachment of individuals

So guess how important things are when it comes to a whole country's economy by studying the emphasis of an entire sector which is healthcare that is supposed to play a vital role in the national development?

The new focus now is at the forefront of services marketing practice and academic research. The impetus for its development has come from the maturing of services; marketing with the emphasis on quality on which we are going to speak later , increased recognition of potential benefits for the firm and the customer, and technological advances. Accelerating interest and active research are extending the concept to incorporate newer, more sophisticated viewpoints. Emerging perspectives explored here include targeting profitable customers, using the strongest possible strategies for customer bonding, marketing to employees and other stakeholders, and building trust as a marketing tool

Recently, customer satisfaction has gained new attention within the context of the paradigm shift from transactional marketing to relationship marketing, which refers "to all marketing activities directed toward establishing, developing, and maintaining successful relational exchanges" thus; we could say that:

"Relationship marketing is an old idea which appeared in the services marketing field as the combination of attracting, maintaining and enhancing the costumer's relationships nevertheless attracting new customers remains an intermediate step in the marketing process; unlike solidification and transformation of indifferent customers into loyal ones and serving customers "patients" as clients in our case here.

So what exactly is this concept of relationship marketing?

1-2/Relationship marketing

Relationship marketing is a new-old concept and (BARLOW and RICHARD,1992) state that it is the idea of a business earning the customers' favor and loyalty by satisfying their wants and needs was not unknown to the earliest merchants. It is known in ancient trade and according to (GRONROOS, 1994) that: "As a merchant, you'd better have a friend in every town." Yet the blossoming of relationship marketing, the creation of a conceptual framework for understanding its properties and studying its possibilities, was slow to develop. Until recently, marketing's focus was acquiring new customers. Formally marketing to existing customers to secure their loyalty was neither a top priority of most businesses nor a research interest of marketing academics.

The thing that facilitates relationship marketing the most is the repeated and continuous contact between the two parties that a service requires "customer and service providers" Moreover, product intangibility often requires reselling efforts

The most important thing to know about intangible products is that the customers don't become aware of what they bargained for and usually don't know what they're getting until they don't get it.; only on dissatisfaction do they dwell in keeping customers for intangibles, it becomes important regularly to remind and show them what they're getting so that occasional failures fade in relative importance

The core subject as the services marketing field has developed--service quality which we are going to talk about a little later -also has stimulated interest in relationship marketing. The object of improving service quality, after all, is to engender customer loyalty. A natural extension of the strong interest in service quality is growing interest in relationship marketing. Effective relationship marketing should help a company capitalize on its investment in service improvement.

Recently so many companies are praiseworthy because of their innovative way of succeeding by creating new rules of marketing and breaking all of the old ones.

- Instead of commissioning expensive marketing research, wasting huge sums on advertising, and operating large marketing departments, these companies stretch their limited resources, live close to their customers by inspiring to customers that the company would rather do the effort and burry the cost instead of them, and create more satisfying solutions to customers' needs. They form buyers clubs, use creative public relations, and focus on delivering quality products to win long-term customer loyalty.

Investing in relationship marketing is profitable for the firm as confirms the study below:

"It has been demonstrated that profits rise steeply when a company successfully gets to reduce its customer defection rate. Based on an analysis of more than 100 companies in two dozen industries, the researchers found that the firms could improve profits from 25 percent to 85 percent by reducing customer defections by just 5 percent. Not only do loyal customers generate more revenue for more years, the costs to maintain existing customers frequently are lower than the costs to acquire new customers" that's how (REICHHELD, 1996) defined it.

So it is for customers because it brings them high involvement, importance, variability and complexity that would push many customers to opt for a continuous, proactive and customized service in addition to the risk-reducing benefits of having a relationship with a given supplier,(CALONIUS,1988) states that customers also can reap social benefits such as allowing service providers to become more knowledgeable about the customer's requirements and needs according to the rule which states that keeping promises, rather than making them, is the key to maintaining and enhancing customer relationships.

Knowledge of the customer combined with social rapport built over a series of service encounters facilitate the tailoring or customizing of service to the customer's specifications

Relationship marketing is an expensive investment that's why it can't be applied to each and every service situation, thus it requires:

1-2-1/Technological advances:

It is true that relationship marketing is the new alternative to mass marketing yet it remains extremely expensive that's why it is used only when needed in affordable and practical cases where potential benefits are better known

Information technology advances are creating the opportunity for firms to move from segmenting markets by groups to segmenting by individual household

Marketers see an opportunity to close the gap that has widened between companies and their customers with the rise of mass markets, mass media, and mass merchants. Database marketing, they believe, can create a silicon simulacrum of the old-fashioned relationship people used to have with the corner grocer, butcher, or baker.

1-2-2/Emerging perspectives

As we defined relationship marketing earlier as attracting, maintaining and enhancing customer relationship; GRONROOS adds the perspectives of noncustomer partnerships, mutual benefit, promise keeping, and profitability.

(GRONROOS, 1990) says that: "Marketing is to establish, maintain, and enhance relationships with customers and other partners, at a profit, so that the objectives of the parties involved are met. This is achieved by a mutual exchange and fulfillment of promise"

According to other researchers relationship marketing includes other types of relation exchange not only with customers but also suppliers, buyers and internal partnerships.

C/Targeting profitable customers

Retaining customers is less expensive than finding new ones and keeping them longer allows finding profitability in them and it is an obvious truth that costs will decrease as (REICHHELD, 1993) says: "In most businesses, the profit earned from each individual customer grows as the customer stays with the company"

And stressing that 'companies aspiring to practice relationship marketing should make formal efforts to identify those customers who are most likely to be loyal and develop their over²all strategy around delivering superior value to these customers'.

Targeting profitable customers for relationship marketing involves study and analysis of loyalty- and defection prone customers, searching for distinguishing patterns in why they stay or leave, what creates value for them, and who they are. Relationship marketing firms need to determine which types of customer defectors they wish to try to save (e.g., price, product, or service defectors) and create a value-adding strategy that fits their requirements and strengthens the bond with loyalty-prone customer

The two existent types of customers require different strategies because both are profitable for the company; we have transactional customers with whom we apply transactional marketing "which focuses on sales promotion and to endeavor attracting more and more new customers. It is characteristically short-term oriented with only little emphasis on customer service" who don't seem to be as profitable as relationship customers who undergo relationship marketing which focuses on the aspects of "attracting, maintaining and enhancing customer relationships" as we mentioned before

The differences between transactional and relationship marketing are summarized in the figure below:

	Transactional marketing	Relationship marketing
Focus on	Obtaining new customers	Customer retention
Orientation to	Service features	Customer benefits
Timescale	Short	Long
Customer service	Little emphasis	High emphasis
Customer commitment	Limited	High
Customer contact	Limited	High
Contact	Operations concern	The concern of all

Figure 1: Differences between Transactional marketing and Relationship marketing

source: Payne, Adrian (1994).

According to the types of bonds or linkages and relative effects we obtain the three levels of relationship marketing which are:

- Level one focuses on pricing incentives to secure customers' loyalty; but the sustained competitive advantages from this approach are very low because of the easy price imitability and customers vulnerability to competitors promotions
- Level two relies essentially on social bonds which include personalization and customization of the relationship by communicating with customers regularly n referring to them by their name during the transactions for example, or by providing continuity of service through the same representative, and augmenting the core service with educational or entertainment activities such as seminars or parties.
- Level three focuses on offering structural solutions to important customers problems through value adding benefits that are not easily affordable(expensive or simply not ready elsewhere), using financial and social bonds, the foundation is even more difficult for competitors to penetrate

D/trust as a marketing tool

Mutually beneficial relationships are the strongest ever; especially when bonded with the partners' good intentions, opened honest and frequent communications, prevalence of similar values and the willingness of the partners to give not just get.

Relationship marketing is built on the foundation of trust, it is critical to the formation of service-based relationships because of the intangibility of services. Most services are difficult to evaluate prior to purchasing and experiencing them, and some services remain difficult to evaluate even after they have been performed. Customers who develop trust in service suppliers based on their experiences with them-- especially suppliers of services with these significant characteristics--have good reasons to remain in these relationships: they reduce uncertainty and vulnerability.

To sum up, communications leads to trust and trust to relationship commitment.

Section 02: determinants of satisfaction

2-1/service quality

Healthcare service quality is observed from different angle, the quality of care delivered in any health care organization is of paramount importance to all the stakeholders in that organization. For the clients it is the primary determinant of what health care provider they would use. For the managers, it is a major goal for the survival of the business of that organization, and therefore the yardstick for measuring managerial competence.

(VANT, 1989) states that For the government it is a measure of their capacity to meet their obligation to the citizenry in ensuring their health related wellbeing.

The evaluation of the customer Satisfaction from service quality is usually in terms of technical quality and functional quality. Usually, customers do not have much information about the technical aspects of a service; therefore, functional quality becomes the major factor from which to form perceptions of service quality. Service quality may be defined as customer perception of how well a service meets or exceeds their expectations. Service quality can be measured in terms of customer perception, customer expectation, customer satisfaction, and customer attitude

The high quality of the service is the key sustainable competitive advantage that will result in satisfied customers. therefore; there is not even an iota of doubt concerning the importance of service quality as the ultimate goal of service providers throughout the world. Many studies talked about the relationship between service quality and customer satisfaction and concluded that service quality is one of the most important determinants of Customer Satisfaction

Significant amounts of intention are oriented to service quality either by researchers or practitioners, which engendered many definitions summarized as follows:

Quality as excellence, quality as value, quality as conformance to specification, and quality as meeting or exceeding customer's expectations

The interest in service quality has been influential in contributing significantly to the growth of the general services marketing field. In business literature, the customer's perception of quality has been the major focus in studies completed on service quality.

Hence service quality is often conceptualized as the comparison of service expectations with actual performance perceptions. On an operational level, research on service quality has been dominated by the SERVQUAL (PARASURAMAN, VALARIE,

ZEITHAMAL; 1985) instrument, which is based on a so called gap model. Gap model is recognized today as a major contribution to the service management literature

The perception of service quality is conceptualized as a comparison of the expected level of service and the actual service performance. Expectations are the wants of consumers, that is, what they feel a service provider should offer.

Perceptions refer to the consumers' evaluation of the service provider Therefore, if the customer's performance perceptions exceed the customer expectations, then the service provider provides quality service

The determinants of service quality split into two big categories:

- namely tangible or technical factors, which refer to technology, physical facilities, personnel, and communication material etc.,
- And intangible factors, which consist of five sub-factors, namely Reliability, Responsiveness, Assurance, Courtesy, and Empathy. Reliability refers to the ability to perform the promised service dependably and accurately.

Responsiveness reflects the willingness to help customers and provide prompt service. Assurance reflects the knowledge of employees and their ability to inspire trust and confidence. Courtesy refers to the kind behavior of employees to the customer. Empathy refers to caring, individualized attention the firm provides its customer.

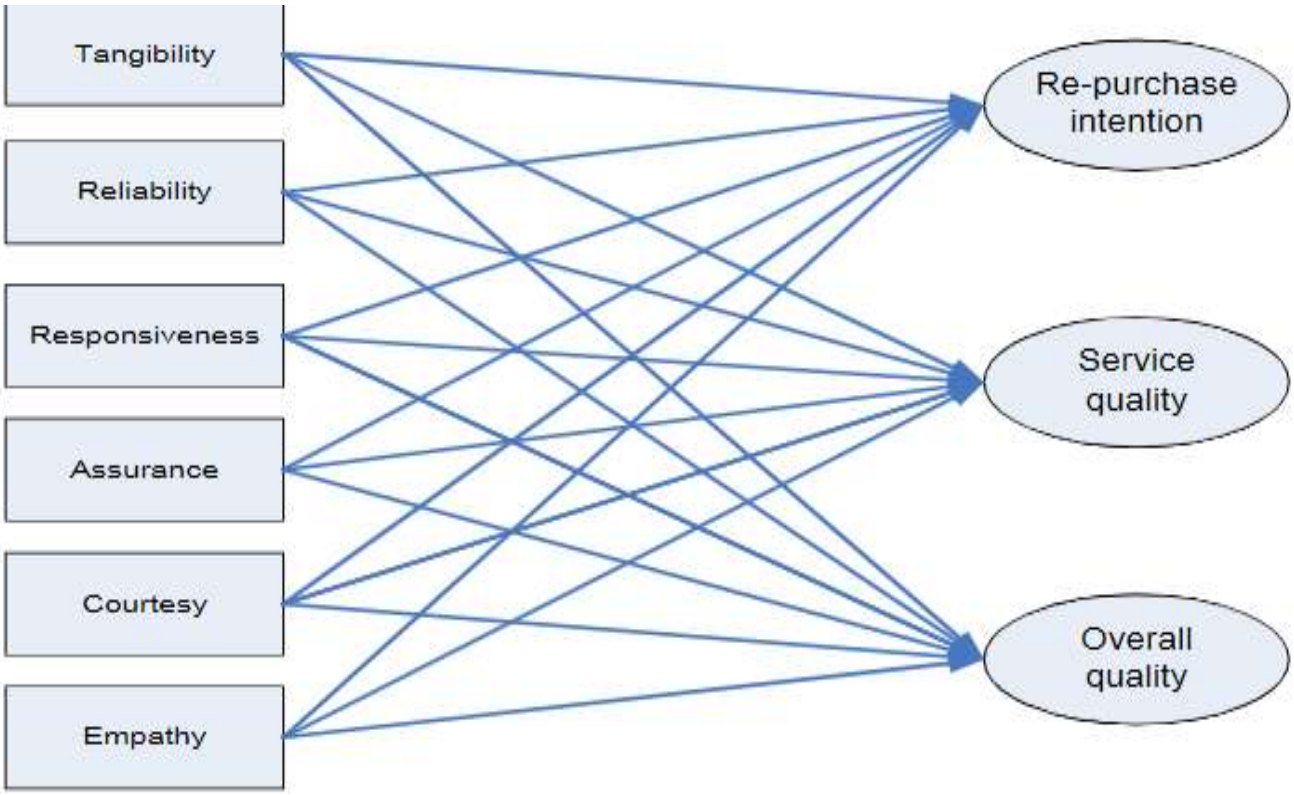

Figure 2: model of the criteria's of service quality and their impact on customer's behavior

SERVQUAL is the most likely used model; suggested by Parasuraman, it identifies the gap between the perception and expectation of the customer

As for the levels of quality in healthcare sector we have these three levels:

Quality of healthcare organizations has been analyzed by different approaches such as the one related to care levels, compliance to sector regulations, attention, and respect of commitments to users by the organizations. 'Many experts have attempted to define quality. While definitions vary, there are three standard levels of quality that are accepted today'.

The first is conformance quality and it represents the most basic level of quality; In particular, conformance quality means ensuring that the outcomes of the work meet the minimum standard set by the organization.

The second level of quality is requirements quality; in this type of quality, the supervisor is responsible for meeting customer expectations, so that he is perceived as running a good organization.

The highest level of quality is quality of kind, where a service exceeds customer expectations or delights the customer. To achieve quality of kind, the supervisor must know performance-improvement techniques, increase motivation of employees, and continuously works improve to the product.

Today many health organizations use DMAIR (design, measure, assess, improve, redesign) as a cyclical process to ensure continuous quality improvement, which is very similar to the DMAIC (define, measure, analyze, improve and control) process used in Six Sigma projects.

Health service quality can be understood as:

• Technical and professional quality: evaluating if the service offered meets the needs, defined by professionals who provide care and also if procedures and techniques are necessary to meet the needs of the user:

○ proper definition of the technical content of the services provided with respect to a set of normative references (including medical- scientific documentation);

○ Staff qualifications (training, application of knowledge, and ethical behavior);

○ Proper execution of investigation, analysis, and diagnostic activities, which are essential requirements for therapies performed.

• Quality of management: the ability to use the available resources efficiently through an organizational system that limits waste, and work under constraints and directives imposed; • Quality perceived by the user, which is the tool for the organization to understand the needs of the same user and to meet its expectations.

2-2/pricing

According to (MITTLLA and AL, 2000) price satisfaction has five dimensions also called price fairness service and monetary costs

-price transparency: clear, comprehensive, current and effortless overview about a company's quoted prices

-Relative price: Price of the offer compared to that of competitors

-Price confidence: Customers' certainty that the price is favorable

-Price reliability: Fulfillment of raised price expectations and prevention of negative "price surprises"

-Price fairness: Consumers' perception of whether the difference between the socially accepted price and another comparative party is reasonable, acceptable, or justifiable. Literature on relationship marketing argues that there is positive relationship between the price satisfaction and perceived value. The companies that deliver higher value to the customers are more likely to satisfy them and to increase their loyalty (ZEITHAML, 1988). (MITTLA, 1998) refers to the different stages of consumers' decision making Processes in order to analyze which price dimensions affect global price satisfaction within the respective stages. From the customer's point of view, price problems will differ within the different stages

2-3/perceived value

Relationship marketing scholars argue that that companies that deliver higher Value to the customers is more likely to satisfy them and to increase their loyalty. Customer value can be defined as "a consumer's overall assessment of the utility of a product based on perception of what is received and what is given, thus there is a "get" and a "give" component in the equation. While (BOLTON and DREW, 1991) show that A customer's assessment of value depends on sacrifice (i.e., the monetary and nonmonetary costs associated with Utilizing the service), Customer characteristics, customer intention, while (HELGSEN and NESSET, 2007) concluded that perceived value has a significant effect on customer satisfaction

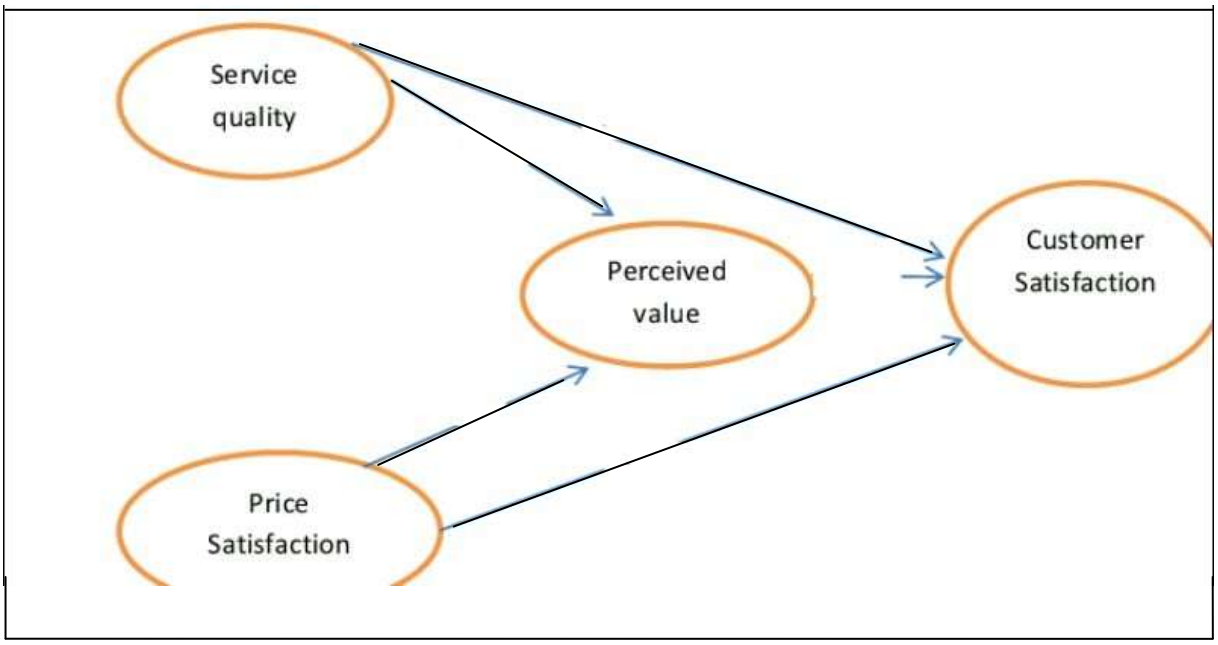

Figure3: conceptual model of satisfaction determinants

benchmarking as an evaluation method

The rated importance of service components will be used as a benchmark for assessing rated satisfaction with services where both parameters are rated on the same scale of five. The difference between rated importance and rated satisfaction of any component will be termed the Service Gap. Benchmarking has become necessary yield evidence of moderate to high patient satisfaction despite the well- known poor standards in most public hospitals. Tracking changes over time is also difficult for researchers and stakeholders, especially for managers in planning and following improvement efforts. It is expected that rated importance of any component will be reasonably stable over time so that pre and post intervention service gaps can give objective and quantifiable measure of continuous quality improvement efforts. Using a patient determined benchmark ensures that patient centeredness and acceptability as a dimension of quality of care is being addressed. It also serves to put in proper perspective the similar numbers assigned to quality ratings in different health services and socioeconomic settings as it incorporates the interaction between existing realities, patient values and experience specific to those settings.

Section 03: Corporatization of the public sector

3-1/definitions of the corporatization

Corporatization refers to the restructuring or transformation of a state-owned asset or organization into a corporation. These organizations typically have a board of directors, management, and shareholders. However, unlike publicly traded companies, the government is the company's only shareholder, and the shares in the company are not publicly traded as KENTON, (W). (2007) defined corporatization retrieved form https://www.investopedia.com/terms/c/coporatization.asp

3-2/goals of corporatization

The main goal of corporatization is

- To allow the government to retain ownership of the company while allowing the company to run as efficiently as its private counterparts. Government departments are often inefficient due to internal bureaucratic conventions. Additionally, the government may consider that joining the private sector might improve a company's performance. If this is the case, the government might conduct an offering on the stock market to divest the organization.
- To better reflect the concept of health care quality studies and researches on corporatization and customer satisfaction were led so it is important to implement an appropriate system that affects in an integrated way, health-staff contribution, customer satisfaction and the performance of the entire organization.

Corporatization occurs when a government attempts to reorganize the structure of a government-owned entity into one that resembles a private entity.

While corporatized companies tend to have a board of directors, management, and shareholders but the government is the only shareholder, and the shares in the company are not publicly traded.

The goal of the government is to retain ownership while allowing the entity to operate efficiently and competitively.

The advantages and disadvantages of increased competition and market driven elements within the healthcare sector have been extensively debated internationally for year

The discussions have primarily concerned what roles public and private caregivers should have and to what extent profit-driven companies should be encouraged or hindered to act within the healthcare market. Political and economic forces have been driving development that has occasionally encouraged and at other times hindered privatization and corporatization.

Organizational autonomy can be a boost the corporatization, if it is adequately managed and supported.

Initially, the reform of choice was to give hospitals some degree of management autonomy. Limited success with this type of reform in some settings led policymakers to go a step further by transforming some of their state-owned hospitals into public corporations. The path breaking reforms of this genre, which occurred through the creation of Hospital Trusts in the United Kingdom and Crown Health Enterprises in New Zealand in the UK and New Zealand, drew world-wide interest. Soon many developing countries such as Hong Kong, Singapore, Malaysia, Indonesia, Tunisia, and Argentina were attempting similar reforms. Often they were accompanied by parallel reforms in the overall health policy framework, provider payment system, and competitive market environment.

3-3/process of corporatization

KENTON, (W). (2007) states that in the process of the corporatization of public health it important to spread enterprise management tools, such as the development of managerial skills, quality improvement, marketing and human resources management. These tools are also crucial in supporting healthcare organizations. corporatization retrieved form https://www.investopedia.com/terms/c/coporatization.asp

An effective and appropriate use of knowledge and economic resources may enable the continuous improvement of quality. The corporatization of public health has created an opportunity to add value to the quality of care not only for the management size and

control of expenditure but also for the technical–professional dimension to the various levels of intervention.

The question of how the employees, who are on the frontlines of healthcare service, are affected has not been given very much attention. A positive work climate is assumed to be important in order for patients to receive good care. The work climate within healthcare is consequently not only important for the large group of people working within the healthcare sector but also for patients and their relatives.

Privatization and corporatization have been described as potentially very stressful events for the employed—events that imply extensive uncertainty about the future. This dissertation presupposes that privatization and corporatization are changes that, like other organizational changes, can 3 present increased uncertainties. This uncertainty may affect the work climate and lead to more negative work related attitudes and decreased health (BORDIA, HUNT, PAULSEN, TOURISH, DIFONZO, PAULSEN and AL, 2005). Nevertheless, the repercussions of changes can look different within the same organization.

Some of the reasons behind the healthcare sector's corporatization are:

- Long waiting time, poor facilities, cost of services and poor patient provider relationship. The studies also found that majority of the clients in the public hospitals are of the lower social class and that despite the well-known poor state of facilities, excruciatingly long waiting time, and patients still assessed the quality of care as satisfactory
- In addition to the possibility of the periodic assessment to guide the improvement
- And as finality; There is that need to understand what our patients value, determine their satisfaction with services they experience and the existing gaps between what they value and what they experience in the clinics in order to develop a patient centered metric to guide and track efforts at quality improvement and satisfaction.

3-3-1/ Management Reforms

Many attempts have been made to address the problems in publicly run health care delivery systems through management reforms. These reforms have included efforts to

strengthen the managerial expertise of health sector managers both through training of existing staff and through changes in recruitment policies to focus more closely on managerial skills. Commonly, efforts are made to introduce improved information systems to facilitate effective decision-making. In addition, in some systems, clinical directorates have been created, and benchmarking of departmental performance has been introduced so said (SALTMAN AND FIGUERAS, 1997)

Many of these efforts constitute part of the growing trend of reform of public hospitals by applying recent "best practice" management techniques from private companies. Frequently, attempts are made to introduce business process reengineering, patient focused care, or quality-improvement techniques. However, attempts to implement these new management practices have been seriously constrained by the public sector context in which public provider organizations operate. Private sector organizations have introduced recruitment and compensation policies based on the best "personnel management" techniques for finding and motivating high performers. Where attempts have been made to apply these methods to public hospital systems, civil service constraints have blocked or undermined them. A critical barrier to applying "best practice" principles from the private sector is the broad lack of control that public sector managers have over factors of production. Thus, although methods for reinvigorating private organizations have sometimes been successfully transferred to public hospitals and systems, most attempts have been impeded by the common constraints generated by public sector control structures. Indeed, the attempts to apply private sector management principles to public delivery of health services has added momentum to the organizational reforms discussed below.

3-3-2/ Funding; Payment Reforms

Reform of the funding and payment arrangements for public hospitals is another common approach to address problems with productivity, efficiency, quality, and responsiveness. Problems with productivity and efficiency are commonly addressed by altering the structure of funding or payments to providers. These payments reforms usually tighten the link between resource allocation and delivery of specific outputs. Examples include retrospective fee-for-service, per diem, or case-based payments. Some reforms try to encourage efficiency by shifting expenditure risk onto the providers via capitated payments or prospective global budgets. Different structural changes are made

to funding and payments systems to address concerns about clinical or consumer quality or responsiveness to users. These payments reforms usually tighten the link between resource allocation and user or payer selection. Examples include limited or fully competitive contracting with providers, fund-holding with patient selection, and demand subsidies (health vouchers to be used with providers or insurers). None of these instruments is perfect. Each helps achieve one goal at the expense of others. Systems that improve productivity encourage supplier-induced demand. Systems that better contain costs usually encourage shirking and low productivity.

The incentives created under each payment structure can be powerful and often create some degree of overshoot that must be addressed. Most systems are not fully understood, nor are measures to compensate for the overshoot, or known disadvantages. This often requires a mix of multiple payments structures, so that the positive incentives of one element of the payment counterbalances the negative features of the other. An example is the frequent combination of capitation elements with fee-for-service in areas where productivity is especially important. For payments system reforms to achieve their objectives, evidence strongly suggests that reforms must also take place that encourage or enable providers to respond to the new incentives. As discussed below, organizational reforms are more complements to payments reforms than substitutes. Neither may be effective on its own. A similar conclusion may be reached regarding management reforms. Much as these management and funding reforms may be needed to improve the performance of health care delivery systems, in themselves they have led to limited results. The general conclusion is that such reforms have often been unsuccessful because they did not get at the roots of the problems of poor incentives inherent in the organization of health service delivery in the public sector.

While most organizational reforms endow the hospitals with formal claims to residual revenue in different categories, the structure of the payments system will directly determine whether this claim has any real meaning or incentive effect. If, for example, services must be delivered at prices less than cost, there will be no residual to claim. Thus, the relationship of costs to the price-setting and capital-charging formula in the payments system is a critical determinant of the incentives of the model. The crucial factor is whether marginal cost-saving effort on the part of the provider can generate revenue flows that the provider can keep. As hospital managers start to cost out their activities, the payment system (or price setting or regulation) will determine which

services cover their costs. They will reduce internal cross-subsidization where possible. If hospitals have been playing a substantial safety net role, by generating funds from some services to cover costs of services delivered to needy portions of the population, then the payments system will need to take this into account. The payments system will determine the degree to which unfunded mandates based on internal cross-subsidization become explicit, and funded.

3-4/problems with corporatization

The main problems with corporatization are rooted in the failure to effectively depoliticize decision-making in a sustainable way.

- First, the board or management have not often been given responsibility for fulfilling a sufficiently narrow and clear set of objectives.
- Second, financial accountability has not been created, partly because managers are simply more informed about costs and turnover.

This problem has been exacerbated in the many instances where enterprises have continued to be responsible for delivering some goods or services without remuneration. Reference to this unfunded mandate often provides an excuse and refuge for poorly performing management, since it makes it impossible to benchmark its performance with other providers not carrying that burden. In most cases, governments have been unable or unwilling to truly expose corporatized enterprises to competition. Nor have they been willing to limit capital funding to what can be obtained commercially, instead giving ad hoc capital injections to troubled enterprises. This has substantially reduced market pressure. Governments have rarely succeeded in removing various systemic privileges for corporatized enterprises.

Beneficial regimes for price setting, capital allocation, purchasing, and tax provisions all have undermined the creation of a level playing field. In most cases, market forces have not been allowed to play their full role in creating accountability under this type of reform.

Perhaps the most obvious behavioral determinant of the reform model influenced by the payments systems is market exposure.

When hospital reforms entail a shift to earning revenue by delivering services "in a market," the issue of what kind of market emerges becomes crucial. Often the government is the largest or only buyer. In this case, the process and terms on which the government purchaser engages providers may well determine the degree of pressure they are under to "deliver the goods". In other cases, there may be many purchasers, public and private, individuals or large purchasing agencies. The issue of how much and what kind of competition emerges is critical in creating pressures for performance on the hospital

Limitations

The limited evaluation that was possible highlighted several important problem areas.

- First, reform objectives often were not clearly stated, making it difficult afterward to assess successes and failures in achieving the objectives.
- Second, the main reform levers altering the incentive regime of the organization and the external environment must lead to changes in the behavior of providers and patients before their net effect shows up in final impact indicators in terms of health outcomes, efficiency, equity, and quality. Changes in the behavior of providers and patients provide proxies for impact.
- Third, without explicitly anticipating some of the potentially negative consequences of the reform (such as the financial burden of user fees on the poor) and introducing mitigating policies (such as subsidies or exemptions), the corporatization of public hospitals runs a high risk of being associated with some serious health, efficiency, equity, and quality trade-offs. Many of these negative consequences could have be avoided by looking at the impact of the corporatization of hospitals on the overall structure of the health system and making compensating adjustments in its structure.

To sum up it is important to note that:

- Corporatization reforms have evolved based on efforts to mimic the structure and efficiency of private corporations while assuring that social objectives are still emphasized through public ownership.

- Under corporatization, provisions for managerial autonomy are stronger than under autonomization, giving managers virtually complete control over all inputs and issues related to production of services. The organization is legally established as an independent entity and hence the transfer of control is more durable than under autonomization. The independent status includes a hard budget constraint or financial "bottom-line" which makes the organization fully accountable for its financial performance with liquidation at least theoretically being the final solution in case of insolvency. The greater latitude of management is complemented by market pressures as an important source of incentives, crucially including some element of competition or contestability.
- In practice, when a hospital is corporatized, it is usually established as a private corporation, although it is still publicly owned.
- The accountability mechanisms are anchored in the creation of a board of directors and some form of corporate plan, which is a binding agreement between the hospital (and the board) and the relevant supervisory agency. This corporate plan contains financial performance targets such as profit or rate of return on assets or equity, dividends and reinvestment policy. These targets usually require the hospital to earn commercial returns at least sufficient to justify the long-term retention of assets in the organization and to pay commercial dividends from those returns.

Privatization of the public sector (extra solution)

1-5-1/definition of privatization

The most extreme version of "marketizing" organizational reforms is privatization. This reform entails transferring a public hospital to private ownership, either as a for-profit or nonprofit organization. Nonprofit privatization is conceptually quite distinct from for-profit privatization and will be discussed separately below. Privatization naturally removes the hospital from all direct control of the hierarchy of government officials or public sector rules. The organization is thus fully independent of the hierarchy, although the management is likely quite constrained by the new owners. All incentives come from opportunities to earn revenue, and the incentives are relatively strong, since private owners or shareholders now are the residual claimants on extra revenues, now called "profits." It is

the combination of these two forces that drives the high- incentive features of this model—complete exposure to a market to earn revenue and owners who are strongly motivated to capture the revenues and monitor the management.

Figure3: model of governance in public hospitals

Explanation of the figure above:

Governance is commonly defined as the relationship between the owner and management of an organization. Good governance is said to exist when managers closely pursue the owners' objectives or when the "principal-agent" problems have been minimized. Governance is usually not a problem in small businesses or organizations where owners can directly observe and evaluate managerial performance. From observing successful large private organizations, experts have identified these key ingredients for good governance:

1• Objectives Narrow, clear, non conflicting:

Objectives of owners translated into narrow, clear, and measurable criteria for management performance. Managers in a private corporation can be monitored relatively easily because owners have two objectives: maximize profits and maximize share price, both observable and measurable. • Supervisory structure. Responsibility for supervising management is vested in an effective, professional body (board of directors) whose members themselves have clear responsibilities and accountabilities.

• Competitive environment:

A competitive environment eases monitoring and motivates management. Competition in the product, labor, supply, and capital markets promote managerial efficiency by forcing the adoption of the most efficient production arrangements in order to stay competitive and capture market share. Competition in the product market allows owners to compare performance of the firm (and management) with other firms and diminishes monopoly rents, which might be misallocated by management, obscuring weak performance. Ability to monitor performance combined with a competitive managerial labor market allows owners to compare performance of company managers and to motivate managers through rewards and job security. Well-functioning market institutions (e.g., stock markets) and accounting standards drastically reduce the costs of monitoring management. Profits from one company can be easily compared with similar companies in the sector. Share prices can be easily observed.

Why does governance fail in public healthcare institutions?

• Internal stakeholders disagree:

Defining narrow objectives is hard in health because there are multiple interests in government who may not agree on what the key objectives are or ought to be. Government-owners may have many objectives in the sector and do not know their key objectives or their relative priorities.

• Clear objectives and priorities reveal trade-offs:

Specifying objectives and priorities can make explicit what is not a priority and what is not going to be delivered/funded by the state. This is often politically costly.

• Challenging new tasks for bureaucrats:

Creating alternative mechanisms to pursue other sector objectives (besides organizational efficiency) is hard because it requires governments to engage in more complex activities (like contracting, purchasing, and regulation). Under an integrated public system (budgetary organizations), governments can functionally pursue sector objectives through implicit understandings that they would transfer resources of x-amount and the hospitals would provide services in some form or another to the population that comes through the door. Under an organizationally reformed system, the government would have to identify

what services would be delivered to the poor (for example) and purchase (or sometimes mandate) their delivery.

• Bureaucrats prefer direct control and discretion:

Even when alternative accountability mechanisms exist, politicians and bureaucrats will usually prefer ad hoc direct interventions with fewer constraints on their relations to the hospitals. Lack of constraints on these interventions creates many problems. Governments that are trying to improve governance through emulation of the corporate model will need to enhance their capacity to develop and implement sector policy through indirect mechanisms such as contracting and regulation. They must create structures for administering the new accountability arrangements and for restraining ad-hoc intervention by politicians and bureaucrats.

Examples of countries where reforms were implemented on healthcare sector

- New Zealand witnessed improvement in some performance indicators (allocative efficiency, cost transparency, and enhanced equity in access). On the whole, the reforms were not, however, viewed as successful. As a result, the government that came to power in 2000 substantially reversed the reforms. This lack of success is largely attributed to fundamental alterations made in the financial regime of the reform model as well as weaknesses in the implementation process.
- The 1995 hospital reforms in the State of Victoria in Australia were driven by a desire to increase efficiency, and the recognition that this would require substantial rationalization. Rather than having a government-driven rationalization plan, the reforms were designed to enable this process to occur in a decentralized manner. Thus, the reforms integrated groups of metropolitan hospitals (and subsidiary providers) into several networks, which could then compete with each other.
- As in the case of New Zealand, the hospitals in Victoria were already fairly autonomous. Hence, the reforms did not focus on enhanced autonomy, but instead concentrated on introducing more corporate-like operation at the network level. Many of the desired improvements that took place, including rationalization, resulted from the combined influence of the hospital reforms and a Diagnostic Related Group (DRG) performance-based provider payment system. The driving force behind the rationalization that took place appeared to be the organizational

reforms that set up the network hospital structure rather than changes in decision rights or other incentives of any individual hospital.

- In 1991, Hong Kong policymakers believed the biggest problems in their hospitals related to rigidity and lack of management expertise. They designed their reforms to address these issues. New incentives were not a central element of their organizational reform introduced in Hong Kong, perhaps because of the generally well-performing government apparatus that already existed. In particular, the Hong Kong reform was not designed to rely on markets or market-like pressures to enhance performance. Rather, policymakers created a single new corporatized Hospital Authority which was granted significant autonomy and enhanced administrative accountability arrangements. The reform integrated all public and publicly funded hospitals, constituting almost 90 percent of beds, into this newly created autonomous legal entity. The Hospital Authority was encouraged to undertake managerial and structural changes that would make it function like a corporation. The reforms gave the Hospital Authority a great deal of day-to-day freedom, relying on annual performance targets for accountability. The Hong Kong reform was relatively successful on a number of fronts but of mixed success in improving quality. Consumer responsiveness and queues, in particular, remain issues. Accountability relied virtually entirely on the effectiveness of the performance-measurement system, since there were no other sources of performance pressure, such as output related payment, hierarchical control, or consumer choice. Evidence to date shows that this system is improving, yet still falls short of making the Hospital Authority truly accountable for performance. As yet there appears to be no penalty for failing to meet performance targets.
- In 1992, Malaysia reformed its newly built National Heart Institute, using a corporatization model that had been applied to other state-owned enterprises in that country. As in many other countries, difficulties arose during implementation, when the original design of the reform was scaled back in a number of areas. The resulting model had some elements that were more reminiscent of enhanced hospital autonomy than the more complete corporatization originally envisaged. But since the re-imbursement system was not designed to fund specific services, or services for targeted individuals, the reform went as far as it could toward

establishing "market-like" incentives and performance pressures, given this constraint.

Conclusion

Lessons from other sectors do not apply directly to a multiproduct organization such as the hospital, where output and health-outcome performance indicators are much more difficult to define and monitor than, for example, kilowatt consumption in the energy sector. Much more refined instruments are needed to guide the behavior of substantially independent hospitals, such as case-mix adjusted payments that are data intensive and require sophisticated patient records and accounting systems. Much new learning has, therefore, had to take place as the principles of "marketizing" organizational reforms were applied to the health sector.

Organizational reform of hospitals is a multidimensional reform that requires coherent changes in a number of critical factors, not just the appointment of a management board or placing the hospital within the remit of company law. Reforms that are introduced in isolation in the hospital sector almost always led to an incoherent policy framework and had many adverse effects on other part of the health sector.

Chapter 02: healthcare industry and its perspectives on the economy

Chapter 2: healthcare industry and its perspectives on economy

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Healthcare marketing was introduced as we mentioned in the previous chapter in 1977 by the arrival of the early 1990's healthcare executives realized that marketing did not consist of spending truckloads of money on mass media advertising.

According to (Richard, Thomas. 2010) Progressive healthcare organizations began to reassess their marketing objectives. Much like their counterparts in other industries, healthcare organizations sought to understand the market, their customers, and their customers' motivations. Now that marketing was a legitimate function, these organizations created high-level positions for their marketing professionals, including vice president of marketing and chief marketing officer.

Chapter 2: healthcare industry and its perspectives on economy

Section 1: generalities about healthcare industry

Today, healthcare marketers have a much better understanding of the markets in which they operate and the customers who reside in those markets.

Sophisticated techniques have been developed specifically for the healthcare market, and a large cadre of professional healthcare marketers has emerged.

There is every indication that the trend toward greater acceptance of marketing will continue and its role within healthcare will expand.

Recognition is growing that marketing is not an optional activity but something that every organization must do. The fact that marketing is being coupled with the business development function means that it will increasingly be an inherent part of corporate operations.

Once the dam broke and marketing made its initial incursion into healthcare, healthcare organizations, led by major hospitals, established aggressive marketing campaigns. Urged on by marketers recruited from other industries, hospitals and other healthcare organizations embarked on whirlwind of marketing activity. The effectiveness of these initial marketing campaigns did not match their proponents' enthusiasm, however, and organizations soon realized that marketing healthcare was not the same as marketing hamburgers. The approaches required for the healthcare arena were not easily adapted from other industries, and much of what was effective elsewhere was not necessarily effective in the healthcare industry.

1-1/ Healthcare marketing birth

Healthcare did not adopt marketing approaches to any significant extent until the 1980s, although some healthcare organizations in the retail and supplier sectors had long employed marketing techniques to promote their products.

Well after other industries had adopted marketing, these activities were still uncommon among organizations involved in patient care.

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Nevertheless, some precursors to marketing were well established in the industry according to (BERKOWITZ, 2006).

Every hospital and many other healthcare organizations had long-standing public relations functions that disseminated information about the organization and announced new developments (e.g., new staff, equipment purchases). The public relations staff worked mainly with the media disseminating press releases, responding to requests for information, and dealing with the press when a negative event occurred.

Most large provider organizations also had communications functions (often under the auspices of the public relations department). Communications staff would develop materials to disseminate to the public and to the employees of the organization, such as internal (and, later, patient-oriented) newsletters and patient education materials.

Some of the larger healthcare organizations also established government relations offices. Government relations staff was responsible for tracking regulatory and legislative activities that might affect the organization, served as an interface with government officials, and acted as lobbyists when necessary. Government relations offices frequently became involved in addressing the requirements of regulatory agencies (Are, C. 2009). "Global Expansion of U.S. Health Care System and Organizations. "retrieved 9/25/09 From www.medscape.com/viewarticle/587903.

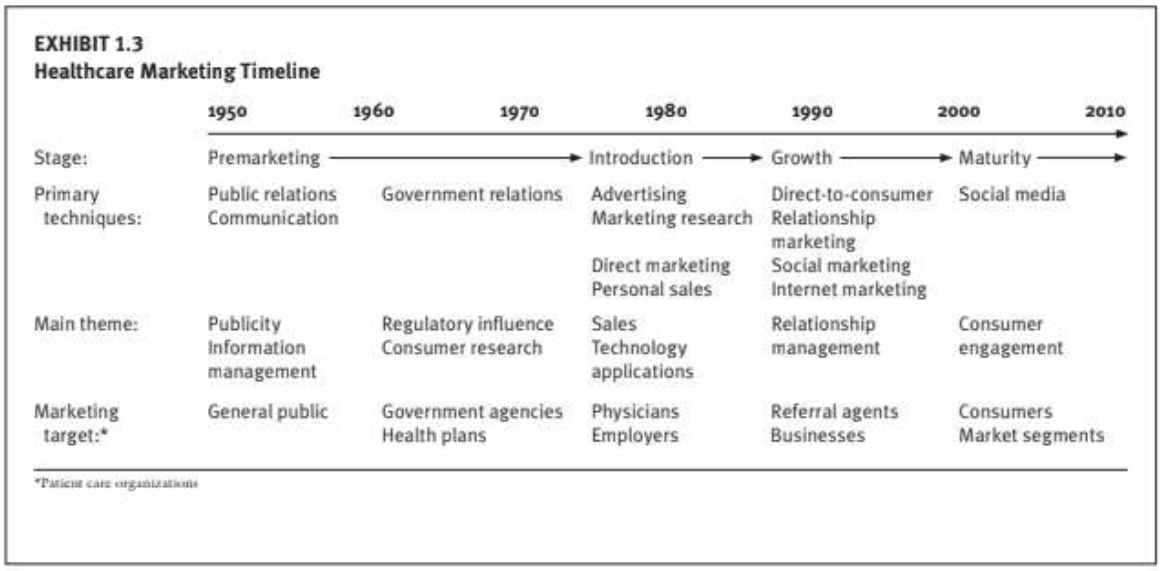

EXHIBIT 1.3
Healthcare Marketing Timeline

	1950	1960	1970	1980	1990	2000	2010
Stage:	Premarketing →			Introduction →	Growth →	Maturity →	
Primary techniques:	Public relations Communication	Government relations		Advertising Marketing research Direct marketing Personal sales	Direct-to-consumer Relationship marketing Social marketing Internet marketing	Social media	
Main theme:	Publicity Information management	Regulatory influence Consumer research		Sales Technology applications	Relationship management	Consumer engagement	
Marketing target:*	General public	Government agencies Health plans		Physicians Employers	Referral agents Businesses	Consumers Market segments	

*Patient care organizations

Figure 4: history and evolution of healthcare marketing

1-2/definition of healthcare industry

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The market is presumed to involve organized groups of sellers, informed buyers, an orderly mechanism for carrying out transactions between sellers and buyers, and a straightforward process for transferring payment for products between buyers and sellers.

The existence of a true healthcare market in an economic sense has been much debated. (CLARK and KOTLER, 1987) cited that in addition to involving the elements named previously, markets operate under the assumption that consumers have adequate, if not perfect, knowledge about the available goods and services, that a rational system of pricing exists, and that the laws of supply and demand apply.

Further, the existence of a market is predicated on assumptions about the motives and activities of buyers and sellers in the market. For example, the assumption that buyers are driven primarily, if not exclusively, by economic motives does not fit well with what is known about the behavior of healthcare consumers. Another assumption from economic theory, that buyers seek to maximize their benefits from the exchange, is also an uncomfortable fit. In healthcare a number of factors operate to prevent the buyers and sellers of health services from interacting in the same manner as buyers and sellers in other industries.

The existence of a market also presumes that there are sellers competing for the consumer's resources and that this competition determines the price of the goods and services offered. In healthcare, however, providers commonly maintain monopolies over particular services in particular markets. Even more common is domination of certain markets by oligopolies of healthcare organizations. Thus, buyers of health services are often limited in their choice of medical personnel or facilities.

As an industry, healthcare also differs from other sectors of the economy in terms of the diverse goals of its key organizations. The packaged goods industry, for example, has the unitary goal of producing, marketing, and distributing products directly to consumers. The goals are straightforward whether the product is detergent, cereal, or office supplies. The intent is to sell as many units as possible while extracting the maximum profit from the transactions. While these industries provide employment for their employees, profits

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for their shareholders and benefits to their communities, these activities are secondary to their single-minded goal of selling consumer products. In other industries, potential buyers who do not have the ability to pay or who, for some other reason, are considered to be undesirable customers can be refused service. Most healthcare organizations, on the other hand, are obligated to accept clients whether or not they can pay for the services and whether or not they are deemed desirable customers. Hospitals are bound by law in most cases to accept patients regardless of their ability to pay. Although providers may have some discretion in accepting patients with stable, routine conditions, emergency departments cannot turn away any patient needing emergency care until the patient has at least been stabilized. Physician offices may require some payment up front from patients who do not have insurance, but there are ethical considerations associated with turning a clearly symptomatic patient away.

This situation means healthcare organizations often provide services that are not profitable. In some cases, this reflects the fact that certain services (e.g., emergency departments at hospitals) may be legally mandated or otherwise controlled through regulation; in others, it reflects the fact that hospitals and, to a lesser degree, physicians must offer the comprehensive services the community requires if they are to remain competitive. Thus, the economic considerations that apply to other industries may be compromised as a result of factors unique to healthcare.

The healthcare industry also tends to be much less organized than other industries in the United States. Often referred to as a "no system," healthcare lacks the coordination and centralized (albeit often informal) systems of control found in other industries. Even industries characterized by cutthroat competition typically have a central clearinghouse of industry data and mechanisms for cooperating for the benefit of the industry overall. In

contrast, the healthcare industry is characterized by fragmentation, discontinuity, and a lack of coordination. It is also characterized by a dismaying lack of information on the industry and its key players. As a result, healthcare lacks the organization that is typically characteristic of an established market.

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Also unlike other industries, healthcare lacks a straightforward means of financing the purchase of goods and services, particularly patient care services. Consumers in other industries typically pay directly for the goods and services they consume, either out of pocket or through some form of credit.

While healthcare consumers may pay some small portion of the cost out of pocket, most fees are paid by a third party, whether a private insurance plan or a government-sponsored plan such as Medicare or Medicaid. The seller may have to deal with thousands of different insurance plans, and the cost of health services is reimbursed using a combination of different payment mechanisms. Thus, it would not be unusual for an elderly patient to have the costs of one hospital visit paid for with Medicare reimbursement, supplementary private insurance reimbursement, and out-of-pocket payments. This arrangement is not found in any other industry and creates a more complicated financial picture for healthcare as quoted from (RICHARD and THOMAS, 2010).

Finally, healthcare is different from other industries in that the normal rules of supply and demand seldom apply. An increase in the supply of health services, for example, does not necessarily result in a decrease in prices, nor does increased demand invariably drive up prices. For one thing, the availability (supply) of services dictates, to a certain extent, the demand for these services. In fact, the historical maxim was: "A bed built is a bed filled." Pent-up demand for health services often surfaces when more facilities become available. As a result, neither the increased supply of beds nor the increase in demand has a significant impact on prices.

1-3/healthcare organizations

Healthcare industry is nothing like others and sets it apart from them are the characteristics that define healthcare organizations (particularly hospitals)

Such organizations may contend that their goal is to provide high-quality medical care. By providing state-of-the-art technology and the physicians, nurses, and allied health personnel to support it, they believe they will be able to attract customers.

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As with the early industrialists, many healthcare organizations once maintained oligopolistic or even monopolistic control over their markets.

Because of their dominance in the market and/or arrangements with competitors, health services providers were often able to ensure a steady flow of patients without having to solicit them. Today, however, few organizations can command that type of loyalty. Nearly all healthcare organizations face some serious competition, and innovations like telemedicine have broadened the scope of would-be competitors.

Healthcare organizations tend to be multipurpose organizations. Although some purveyors of healthcare goods or services are single-minded in their intent, large healthcare organizations like hospitals are likely to pursue a number of goals simultaneously. Indeed, the main goal of an academic medical center may not be to provide patient care at all. It may be education, research, or community service, with direct patient care as a secondary concern. Even large specialty practices are likely to be involved in teaching and research, and although they are not likely to neglect their core activity, they often have a more diffuse orientation than organizations in other industries.

Not-for-profit organizations have historically played a major role in healthcare, and even today, not-for-profits continue to control a large share of the hospital bed inventory. Although physician groups are usually incorporated as for-profit professional corporations, many community-based clinics, faith-based clinics, and government-supported programs operate on a non-profit basis. This “charitable” orientation creates an environment that differs from that of other industries. The financial support that the government provides to some health facilities and programs also creates a different dynamic; from (MACSTRAVIC, 1997)

For some organizations, the unpredictability of government subsidy is an unsettling factor. For others, the assurance of government support means they may not be as vulnerable to the vagaries of the market.

Another factor that sets healthcare organizations apart from their counterparts in other industries is the emphasis on referral relationships. Hospitals depend on admissions from their medical staffs, and staff members in turn depend on referrals from other physicians.

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Indeed, except in emergency situations, patients can gain hospital admission only through a physician referral.

Many specialists will not accept self-referred patients at their clinics; rather, they rely on other physicians to refer patients to them. The same types of referral relationships exist with regard to other services (e.g., home health care, nursing homes).

This situation has become more complicated because health plans may also exert some level of influence over the referral process. Not only do health plans determine which healthcare providers can be used under a particular coverage plan; they may also attempt to control the referral process. In no other industry do parties who are not the end users exert such an influence on the process.

Section 2: healthcare markets and consumers' behavior

2-1/healthcare markets and their definition

2-2-1/defining the market

It is a place where two parties can gather to facilitate the exchange of goods and services, Retrieved from (https://www.investopedia.com/terms/m/market.asp)

... Alternatively, the term may also be used to describe a collection of people who wish to buy a specific product or service such as the Brooklyn housing market or as broad as the global diamond market

Definition of the healthcare market varies with the products involved, competitive environment and the analysis purpose accordingly with the orientation of the organization that is involved in the marketing process

2-2-1-1/geography

The most common method of defining a market is based on geography. A geographically based market is delineated in terms of specified geographic units. Most market research, in fact, focuses on a census tract, zip code, or county (or a group of any of these units) as the

basis for analysis. This type of market area is typically delineated in terms of the "official" boundaries of the geographic units chosen for analysis. Geographically based markets are

popular because analysts and decision makers are familiar with established geographic boundaries; the de facto operating spheres of many organizations often correspond with specified geographic boundaries; and market data are typically collected and reported for established geographic units.

The most common geographic units used by marketers are:

- Political administrative units
- Statistical units
- Census tracts; which are small statistical subdivisions of a county established by the Census Bureau for data collection purposes. In theory, census tracts contain relatively homogeneous populations ranging in size from 1,500 to 8,000.

2-2-1-2/population segments

Markets conceptualized in terms of population segments can be broad or narrow. For example, a market defined as "seniors" cuts a broad swath. On the other hand, a market defined as "seniors who require nursing home care" retrieved from (https://books.google.dz/books?id=4fp2C3yLLD4C&printsec=frontcover&dq=nursing+home+care&hl=en&sa=X&ved=2ahUKEwi63Z7TtvzrAhUQnxQKHdISA2sQ6AEwAHoECAIQAg#v=onepage&q=nursing%20home%20care&f=fals)

is a much narrower segment of the population. Similarly, the nature of the market could depend on whether one is speaking in terms of a broad range of services (e.g., comprehensive inpatient services) or a narrowly defined individual service

2-2-1-3/consumer demand

A third way of delineating a market is from the perspective of the service itself that is, the market is defined by consumer demand. For example, healthcare organizations may seek to identify geographic areas in which there are large concentrations of potential patients for a particular service. Geographically defined and demographically defined markets start with the

general characteristics of the population and work down to its specific healthcare needs, whereas demand-based markets start with a particular need or service, and work backward to identify the relevant population of consumers. In this instance, markets are defined in terms of their healthcare needs rather than broad geographic or demographic categories.

2-2-1-4/opportunities

It is said by (Richard and Thomas, 2000) that within a shortage of providers or lack of facilities in that area. An area characterized by a lack of competition is obviously attractive to an opportunistic organization. In other cases, the number of providers may be adequate, but their fragmentation may offer an opportunity for an organization that can appropriately package its services.

Areas (or populations) characterized by a high level of unmet healthcare needs may present additional opportunities. In other words, an area (or a population) may appear to need a certain level or type of service, but, for whatever reason, the service is not available. For example, a specified population, according to a demand model, should record a certain number of mammograms per year based on its size and composition. If the number of mammograms performed annually is significantly lower, this population may have an unmet need. Note that many unmet needs exist in populations with limited ability to pay for services. Depending on the type of organization performing the research, these populations may or may not be appropriate target candidates.

Similarly, opportunities may exist in areas where a gap analysis indicates a service shortfall or a mismatch between needs and services. The number of physicians or hospital beds that a given population can support is usually determined using various computer models. If the number of physicians and/or hospital beds located in the area falls below the expected number, there may be opportunities in that market.

2-2-2/profiling a health market

When boundaries of a market are established according to the previous criteria's we can process to profiling operation which consists of defining the:

- Market size

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- Market composition
- Health status
- And health service demand: which is translating health conditions (diseases and health problems example: Typically, the level of need will be expressed in terms of a percentage of the population or a rate of some type). into demand for health services

Section 03: payer's mix

A factor that has become increasingly important in developing a market profile is the consumer's ability to pay for health services. The analyst must determine the potential payer mix of the target population and estimate the expected level of reimbursement for a particular service. Given that different payers (e.g., commercial insurers, Medicare) offer different levels of reimbursement, the effective payer mix will ultimately determine the actual level of payment as stated (Richard and Thomas, 2014)

The two bases for determining a target population's ability to pay are household income and type of health insurance coverage. For major health problems (i.e., problems requiring hospitalization and/or intensive services), the level of insurance coverage is the more important consideration. Employer--sponsored commercial insurance generally affords the highest level of reimbursement. Other forms of private insurance (e.g., Blue Cross) are also desirable. Although payments under Medicare and Medicaid are essentially guaranteed, reimbursement rates under these government insurance programs have historically been lower than those of commercial insurance plans.

For elective services, the level of income is usually more important than the type of insurance coverage.

The potential emergence of managed care as a force in the ALGERIAN market will obviously change the playing field. Unfortunately, information available on managed care at the market level limited and primary research is often needed to gain an understanding of managed care penetration and the market shares of managed health plans.

3-1/consumer behavior in health sector

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(Richard and Thomas, 2014) say that a consumer is a person who's ready to consume goods and services anyone who has a want or need for (and presumably the ability to pay for) a product can be considered a potential customer. According to this definition, the entire ALGERIAN population is a market for some type of healthcare good or service.

Healthcare organizations have not historically viewed consumers In this manner. Individuals were not considered consumers of health services until they became sick. Until recently, the general assumption was that none of the 45 million ALGERIAN citizens was a prospect for health services until one sought care. Thus, healthcare providers made no attempt to develop relationships with non-patients. Marketers in the consumer goods industries pursue potential customers much more aggressively than do marketers in healthcare, assuming that nearly everyone

Healthcare consumers differ from other consumers because they

- Often do not know the price of the services they consume, which reflects the unusual financing arrangements characterizing healthcare and the patient's lack of access to pricing information. Unlike that of consumers in other industries, the behavior of healthcare consumers is seldom affected by cost factors.
- Have very limited information and knowledge about the operations of the healthcare system
- Their behavior and purchase decisions are highly influenced with like fear, pride, and vanity influence the behavior and decisions of patients and their families

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Chapter 2: healthcare industry and its perspectives on economy

Conclusion

Marketers of consumer health products typically used the same techniques as companies marketing other types of consumer products. However some approaches unique to healthcare emerged.

Marketing was one of the business practices that healthcare organizations came to accept. The margin necessary to support ongoing operations and continued development of the organization had to be nurtured, and the role of marketing in this process came to be recognized. If revenue was to flow to the bottom line, the organization had to increase customer traffic, sales volumes, market share, and all of the other indicators normally used in industry. Marketing was recognized as critical to the processes that would ultimately contribute to the bottom line. NFPs (non for profit organizations) came to recognize the need to turn a profit and the importance of profitability to their continued viability, and ultimately came to appreciate the contribution that marketing made in this regard.

Chapter 03: marketing plan and strategy setting

Chapter 3: Theoretical marketing plan and strategy setting

> The question will no longer be, "To market or not to market?" as asked by: QUELCH, J. (2009). Harvard business review, study market success and failure.

But it will ask the extent to which marketing will contribute to the success of the organization. A growing emphasis on grass-roots marketing has been in evidence. Marketers are developing the ability to attract more and "better" customers and are increasingly focusing on improving customer satisfaction and applying the following steps.

Chapter 3: marketing plan and strategy setting

Section 1: presentation of the internship institution

1. 1 Historique of the institution:

The institution is known actually as « Clinique Médicochirurgicale Infantile » or clinic for children medico-surgery; specialized in heart surgery for children whose age is between 0 and 15 years old

Children with natal hearth illness (congenital) are treated in this clinic either by surgery or through interventional catheterize.

Before specializing in heart surgery; the establishment used to be a rest center during the French colonization and used to belong to the French security fund.

Casmica (caisse de la sécurité sociale de la métallurgie et des Industries) or (social Security fund for metallurgy and industries, merged in 1963 with other funds to become ex CASORAL) it used to serve as a rest and convalescence center for the patients who have insurance policy as well as a holiday camp for their children.

From 1976 the institution got specialized on orthopedics receiving children with physical handicaps for surgery operations and functional reeducation and rehabilitation.

From 1980 the orthopedical clinic got specialized on children surgery of the heart and became what it is now CMCI (clinique medicochirurgicale infantile) and then 3 medical services were added:

- Cardio-vascular surgery
- Heart pediatrics
- And resuscitation

In order to allow the doctors to acquire new techniques, the government implemented a cooperation politics with foreign hospitals with guaranteed internships for doctors, physicians and other executives, and through organizing missions for foreign doctors to take part in complicated and delicate surgery here.

1.2 Presentation of the establishment :

The CMCI of BOU ISMAIL is the only public establishment (+ the clinic of tizi ouzou which depends of the health ministry) that takes on its charge congenital cardiovascular sicknesses (birth malformations and sicknesses) of children aged under 16.

It receives children coming from the 04 corners of the country, for a complete medico-surgical prise en charge of a high quality (interventions of heart surgeries and interventions of catheterism).

This highly specialized establishment depends of the work and social insurance ministery in addition to the national fund of the social insured persons (CNAS), and is considered as a reference clinic for the public forces. It insures university internships of high quality by disposing the new doctors of high quality medico-surgical teams and above all, some high tech medical such as the catheterism unit "which is of a very recent generation" and digitized radiology unit too.

La CMCI est implantée au sein d'un ancien aérium hérité de l'ex Caisse Algérienne de Sécurité Sociale (ex CASMICA), au milieu d'une forêt d'eucalyptus et faisant face à la mer.

Bâti en système pavillonnaire, elle est étalée sur une superficie de près de 5 ha, et comprend une administration centrale, 04 blocs d'hospitalisation, un quartier opératoire (02 blocs opératoires, une salle de cathétérisme, une salle de réanimation), une consultation externe, une pharmacie centrale, et d'autres services médicaux annexes

La clinique comprend aussi des blocs de logements de service pour le personnel et d'astreinte médicale pour les médecins, ainsi qu'un Centre d'Accueil de

Parents d'Enfants hospitalisés (CAPEM), et qu'un Cyber Espace pour les enfants hospitalisés.

Reception capacity :

The clinic has the capacity of 86 beds where 71 are especially reserved to patients:

- Pre-operatory: 18 beds

- Hospitalization: 15 beds

- Intensive care: 28 beds

- operating post: 10 beds

Technical set :

Explorations:

- 01 digitized cathétérisme room of a new generation

- 02 consultation room with 02 portable heart echodopplers

- 01 portable echodoppler in resuscitation room

- 01 portable echodoppler

Surgery:

- 3 operatory blocs

- 02 heavy surgical activity rooms

- 0I opened-heart surgery room

Radiology service:

- 01 digitized radiology room

Annexes services:

- Hematology lab

- Sterilization unit

- Central pharmacy

- dental surgery office

- Biberonnerie.

Symbolique fees for the social insured persons: 280 DA for the half-pension services (breakfast+ diner+ spending the night)

1. 3 administrative organization of the establishment :

   CMCI of Bou Ismaïl is run according to the low of the 24th of October 2010 setting the organizational and functional conditions of the structures in charge of the sanitary actions of the social Security organisms.

The article 23 of this note mentions that this clinic is managed by one manager and 04 sub managers as we are going to see later here: (CMCI's manager is Mr. belgacem) who has under his command 04 sub managers:

- Sub-direction of logistics and administration

- Financial sub-direction

- Sub-direction of sanitary and social actions

- Sub-direction of the medical activities

Concerning the medical side, besides the medical SDA the chief executive has (pole chiefs under his command:

- Chief of surgery pole

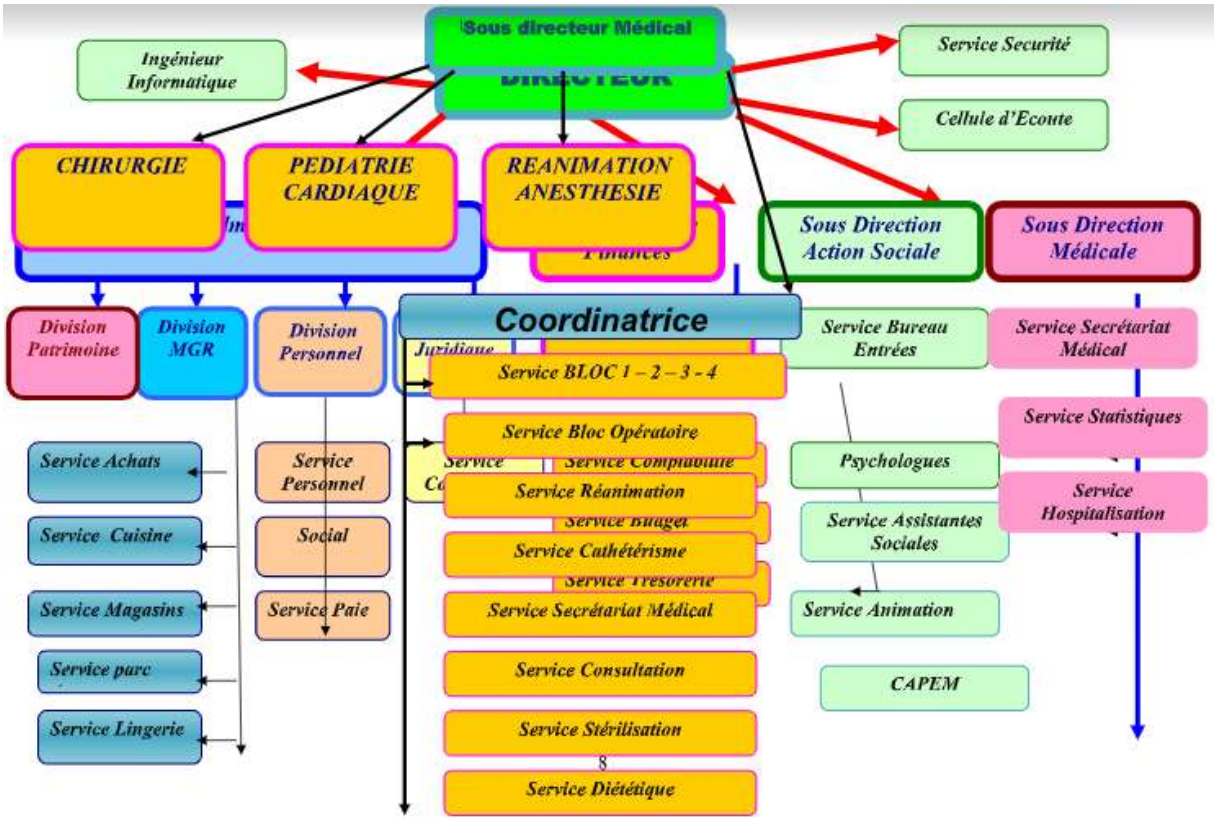
- Chief of cardio pediatrics pole

- Chief of resuscitation pole

- The pharmacist

- The biologist doctor

The clinic organigramme



Based on an official document provided by the CMCI's administration

Figure 8 : the clinic organigram

Section 2: the Hippocratic Oath retrieved from (http://belmont.bme.umich.edu/wp-content/uploads/sites/377/2018/02/1-The-Hippocratic-Oath.pdf)

The oath that should b sworn by doctors to pledge to keep the medical ethics which rule the healthcare sector states that:

I swear to fulfill, to the best of my ability and judgment, this covenant:

- I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow;
- I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

- I will remember that there is art to medicine as well as science, and that warmth, sympathy and understanding may outweigh the surgeon's knife or the chemist's drug.
- I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.
- I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty.
- Above all, I must not play at God. I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability.
- My responsibility includes these related problems, if I am to care adequately for the sick.
- I will prevent disease whenever I can, for prevention is preferable to cure. I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sounds of mind and body, as well as the infirm.
- If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection hereafter.
- May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

Section 3: theoretical marketing planning

Marketing planning is done differently in different organizations. The plan is variously called a business plan, a marketing plan, and sometimes a battle plan.

Most Strategic Marketing for Health Care Organizations marketing plans covers one or a few years; they vary in length from under five to over fifty pages. Some organizations adhere strictly to their plans, whereas others see them as only a rough guide to action. The most frequently cited shortcomings of current marketing plans are lack of realism, insufficient competitive analysis, and a short-run focus.

The marketing plan is one part of the overall set of plans derived from the organization's mission.

The suite of plans will include the Community Health Improvement Plan, the Workforce Development Plan, the Marketing Plan, the Quality Improvement Plan, and the Strategic Plan. This means that these plans should be considered when developing each specific marketing campaign. Each plan is one aspect necessary to fulfill the health district's mission and exist as a unified effort to that end. The basic outline of each of the plans should include background information, purpose consistent with agency mission, goals, objectives, strategies, conclusion and budgets.

In order to build a strategic plan any organization must go through these steps

- Definition of its mission which is providing healthcare, saving lives and in a way or another seeking public welfare and making the world a better place "which is the purpose behind this paper".

We can use peter drucker's classic model (DRUCKER, 1993).of questions:

"What is our business? Who is the customer? What is of value to the customer? What will our business be? What should our business be?" Retrieved from: (https://andrewsobel.com/peter-druckers-five-magic-questions/)

- Then moving along to strategic planning which start with defining the business which is based on the understanding of these elements

-history of the aims, policies and achievements; so in hospitals and health organizations physicians must know and understand why the group was formed, what processes have contributed to its success, and what it has accomplished. Hospital employees should appreciate the origins of the organization, particularly if it is a nonprofit enterprise. Even successful medical product companies communicate this element to their employees and customers. If members of the organization understand the organization's history, leaders can more predictably gauge how they will react to the process as well as the content of changes necessary for strategy implementation. Also, this understanding is critical to

appreciating corporate culture the shared values and beliefs of the firm's members.

Also new employees may receive a marketing orientation, and incentive programs at some organizations turn employees into marketers. This means working more closely with the fund-development department, developing marketable facilities, co-marketing with the community relations area, and developing a long-term affinity with the community. These actions have often led to increased business volume, and marketers can increasingly demonstrate that the business came because of the marketing

-knowing the current preferences of managers and owners by physicians and therapists in order to assure a common agreement on the mission and strive to fulfill it properly

-knowing and studying market environment (swot and five forces of porter analysis)

- Resources. The organization's resources set constraints on the mission statement. These resources are both tangible, such as cash, plant, and equipment, and intangible, such as reputation and image.

- Distinctive competencies. The business should ask itself not only what it does well but also what it does better than other similar organizations. Such competencies are not only clinical, such as better surgical outcomes, but also operational, such as better coordination of care for patients who have complex illnesses, more efficient billing systems, or a more patient-friendly staff.

Generally speaking the business of any organization is defined in term of its output for example, a hospital may say that it does knee and hip surgeries. But Theodore Levitt argued that market definitions of a business are superior to product definitions.

Levitt encouraged organizations to define their business in terms of needs, not products; outcomes, not outputs; Levitt, (T). (1981, may_june). marketing intangible products and products intangibles, Harvard business review. Usa

Thus the hospital that does knee and hip surgery is producing or improving patient mobility; the cancer physician is there to produce hope.

Real leaders should ask themselves and the organization what could our business be?

Answering this question in additions to the others mentioned above allows any organization to know what is its real business and start working on some more realistic roles and the assessment of capital budgeting.

- Customer identification is done once these questions are answered:

Who are our customers? Where are they? What are their characteristics?

"The word 'customers' to include all persons who are impacted by our processes and our products. Those persons include internal as well as external customers.The term 'external customers' is used here to mean persons who are not a part of our company but who are impacted by our products. The term 'internal customers' means persons or organizations that are part of our company." (KOTLER, SHALOWOTZ and STEVENS.2008)

The attribute users is used to precise and designate the person carrying positive actions

After a business has identified its customers and prioritized their importance, it must define its service area. Whereas medical products (such as pharmaceuticals and devices) have widespread distribution, one of the major characteristics of health services is that all health care is local.

Once the firm has determined the scope of its geographic coverage, it must define the segments of the market it seeks to serve. Market segmentation involves identifying a group of current or potential customers with similar characteristics.

The characteristics can be determined by demographics, such as age or sex; service line, such as primary care, infertility services, or mental health; payer type, such as cash-only (as for aesthetic surgery), Medicare, or managed care; or other general preferences.

Value proposition

For most businesses, value is defined as the best product or service one can obtain for a given price or, for a desired product or service, for the lowest price at which it can be obtained. Thus value is most often defined as a trade-off between cost and quality. Although these concepts of cost and quality are important in health care, a third dimension, access, must also be considered. Therefore, an appropriate mix of cost, quality, and access is essential for a firm to deliver customer value. That mix decision must then be reflected in the mission statement.

Of additional importance is managing a value chain. Porter proposed the concept as a tool for identifying ways to create customer value.

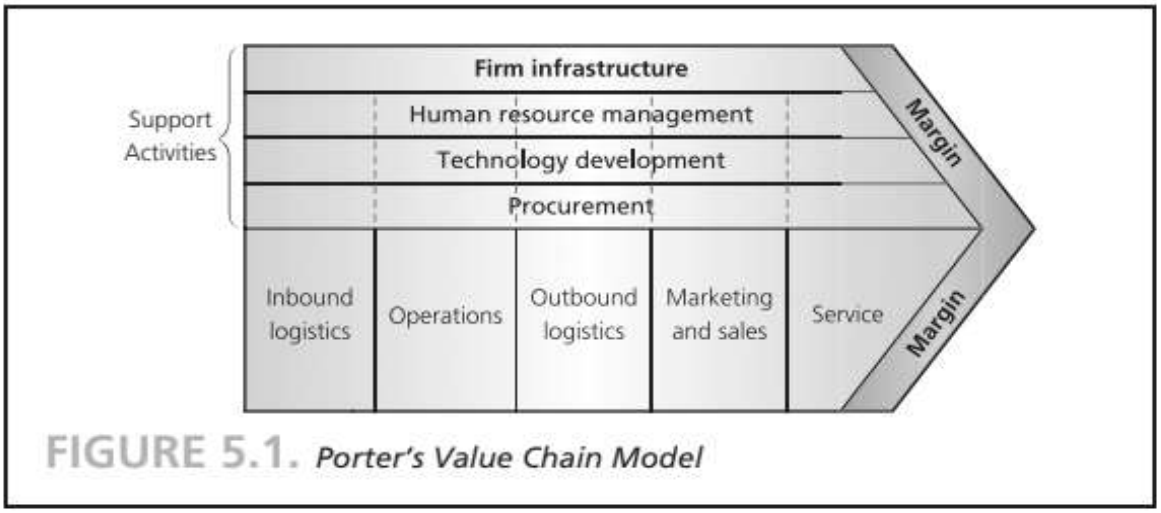


FIGURE 5.1. *Porter's Value Chain Model*

Source: Porter, M. E. *Competitive Advantage: Creating and Sustaining Superior Performance*. New York: Simon & Schuster, 1985.

From (PORTER, 1985).

Success depends not only on how well each department performs its work, but also on how well the various departmental activities are coordinated to conduct core business processes, which include the following:

■ Market sensing. Gathering market intelligence, disseminating it within the organization, and acting on the information

■ New offering realization. Researching, developing, and launching new, high quality offerings quickly and within budget

■ Channel bonding. Developing strong partners on the supply and distribution side of the business

■ Customer acquisition. Defining target markets and prospecting for new customers

■ Customer relationship management. Building deeper understanding, relationships, and offerings to individual customers

■ Fulfillment management. Receiving and approving orders, shipping goods or

delivering services on time, and collecting payment

Goal setting

For goals to be meaningful, they must have at least the following five characteristics:

1. Goals must be clearly tied to the mission statement. For example, if a mission states that a medical group will improve quality of care as perceived by its patients, a goal should be to continuously improve patient satisfaction scores by using a valid assessment tool.

2. Goals must be clearly defined. Organizations should avoid such vague statements as "we want to be the best hospital in our area." More clearly defined goals might be to maximize profitability or provide a certain level of community service.

3. Goals must be measurable. Firms must be able to assign a numerical value to achievement of milestones in order to assess whether they are being reached.

For example, profitability can be evaluated by such measures as return on equity or return on assets. Patient satisfaction can be measured by such indicators as minutes of waiting time as we mentioned in the first chapter or overall scores from patients who felt their physician listened fully to their problems.

4. Goals must be prioritized. There are three reasons for such prioritization. First, some goals are obviously more important than others. Given its mission, values, and resource

constraints, an organization may be able to accomplish only so much in a certain time period. Second, some goals may conflict with one another. An example is managed care companies' desire in the 1990s to increase market share and profitability simultaneously. Finally, certain customers are more important than others. (Prioritizing customers does not mean one may discriminate against patients based on such factors as age, gender, race, and so on.)

5. Goal setting must include a target time by which they must be achieved. Goals must move from abstract concepts into something more tangible. Deadlines for goal achievement can specify either a target number, such as 92 percent patient satisfaction by year end, or a rate, such as 5 percent market share growth each year. If a particular rate of improvement is specified, setting deadlines is similar to the concept of improving "cycle time" in quality improvement initiatives.

The aim of improving cycle time is to accomplish the same number of tasks or more in a shorter period. If overall patient satisfaction was improved by five percentage points in a year, an improvement goal might be to reach that milestone the following year in six to nine months.

Strategy

Although determining an organizational mission and goals are important, one must also have a plan for achieving them. This plan is the business strategy Besanko, Dranove, and Shanley begin their general text on strategy with a series of definitions

The determination of the basic long-term goals and objectives of an enterprise, and the adoption of courses of action and the allocation of resources necessary for carrying out these goals.

The pattern of objectives, purposes or goals, and the major policies and plans for achieving these goals, stated in such a way as to define what business the company is in or should be in and the kind of company it is or should be.

What determines the framework of a firm's business activity and provides guidelines for coordinating activities so that the firm can cope with and influence the changing

environment. Strategy articulates the firm's preferred environment and the type of organization it is striving to become.

I was supposed to do my internship in a healthcare institution (CMCI of bousmail) and because of this covid-19 pandemic and the lock down that lasted for like 6 months it was impossible for me to do my qualitative study which was supposed to be a bunch of semi-directed interviews with all types of healthcare practitioners (doctors, nurses, therapists, administrational staff and everyone in interaction with patients); in order to better know determinants of customer satisfaction in the sector and implement the adequate plan and changes as well as the assessment of the evaluation system.

According to the circumstances we are going to contempt with a projection of the theoretical part mentioned above on the future Algerian potential market of healthcare industry.

The marketing plan is carried out through a series of marketing campaigns. Each marketing campaign will include the major sections of the outline below:

1. Establish a purpose:
    - To enhance quality of life by enhancing health because corporatization make healthcare an industry and inflects it in Commercial businesses which focus on creating financial profit to support their valuation and remain viable.
    - Health care must focus on creating social profit to fulfill its promise to society.
    - To be efficient and productive and earn a sufficient margin to continue to serve and to improve. But when financial metrics rule the day in health care, we sacrifice its fundamental purpose. Best companies have a social conscience, which contributes to their financial success. But most businesses emphasize margin over mission, and health care must emphasize mission over margin.
    - Proximity, humility, shared purpose, trust, transparency, inclusion, empowered execution, and joy. Embracing these concepts will take health care much further so they are considered as main purposes.

- Apply commercial accounting system the one used in any company seeking profit and have the willingness to generate a positive result by the end of the year this can happen through fair and correct pricing of the service provided; with the assessment of a CRM databases could serve to do a proper segmentation of the Algerian population "we will mention the segmentation criteria's in the next section"

2. Assess marketing needs while the resources are cited below:
   Public Sector healthcare infrastructure retrieved from (https://en.wikipedia.org/wiki/Index_of_Algeria-related_articles)

• Health infrastructure comprises 13 university hospitals, 34 specialized hospitals, 460 polyclinics, 1110 medical centers, 3600 basic health units.

• Most health services are yet provided by the public sector, although a small private sector comprising some 20 percent of Algerian physicians also exists.

• As for the private sector, its institutional and regulatory framework leaves much to be desired, and it has been unable to offset the shortcomings of the public sector in the areas of quality and access to care. Resources per 10 000 people 2009

• A network of hospitals and ambulatory Physicians 11.9 facilities are organized into health districts. The districts consist of a Dentists 3.0 - general hospital / polyclinic Pharmacists 2.0 - one or more urban and rural maternity centers, - medical centers, Nursing and midwifery 32.8 - and small, basic health units / dispensaries. Hospital beds

• These facilities are complemented Infrastructure - primary health 2.0 by specialized hospitals and Sources: WHO and center care units.

Public Sector healthcare infrastructure

• Specialized hospitals (EHS) offer (460 polyclinics) treatment in a narrow medical specialty: Basic local structures Maternity, Oncology, Rehabilitation, Ne 1 110

medical centers urology etc. Almost half of the 3 600 basic health units' specialized hospitals are Psychiatric 120 blood transfusion units

- Algeria – total 61 800 hospital beds (2007) TOTAL General hospitals Maternity clinics Specialized hospitals CHU- University hospitals Private Clinics (approx. 6 % of the total)

• The Algerian healthcare system enjoys a considerable level of development, The GDP share of health expenditure is increasing (4.1 % in 2003, 5.6 % in 2009), but remains low in relation to huge modernization needs of the health care infrastructure.

• Algeria's progress towards the 2015 Millennium Development Goals (MDGs) have recently been assessed by the WHO : The country has been judged as not likely to achieve the targets in eight key areas, much like the rest of the African nations covered by the review

. • Quantitatively the numbers related to infrastructure and professionals look fine but the Algerian health care system suffers from significant qualitative failings Primary healthcare establishments are often underutilized, and the various levels of healthcare are used in much less than optimally => Facilities and equipment are afflicted by lack of maintenance and upkeep, and still show high levels of infections and breakdowns.

• The country's epidemiological profile is changing rapidly and such diseases as cardiovascular diseases, diabetes (est. 8 % incidence), obesity, cancer are on the rise

• Nevertheless, the resurgence of "poor country" diseases, such as cholera and tuberculosis, remains health system is largely still that of a developing country according to (World Health Organization. 2020. p. 27-31. Retrieved April 25, 2020)

- Major Healthcare Modernization Plans In 2010 the government has PAST healthcare modernization projects included 2005-2009 the USD 2 billion plan, which envisaged outlined a NEW medical the building of 65 general and specialized hospitals, orientation plan to 2025, which will 76 polyclinics, 168 health centers, 40 treatment be funded to the tune of USD 28.5 rooms, and six sanitary control centers billion in order to improve sanitation and overall hygiene level that have been strongly criticized in the country :
- To double the number of hospitals beds focusing on maternity and cancer wards (to construct 57 cancer treatment From 1960s to 2007 the number of hospital beds centers and 200 hospitals in order to have been reduced dramatically. Today the major increase healthcare access across challenges are related to : the country optimization of professional resources and structures nationwide
- healthcare funding for even the poorest hospital beds in 320 public
- better prioritization of the public investment targets hospitals (investing 1 % of the Algerian budget)
- The government has launched various initiatives to encourage FDI, including privatization, However, a July 2009 meeting of experts highlighted Algeria's need to diversify its bid for FDI to health, information and communication technologies (ICT and tourism. Authorities are committed to economic liberalization, as Algeria Pharmaceuticals & Healthcare Report illustrated by the sale of various enterprises over the past years, including part of the **Saidal** pharmaceutical group
- The government is committed to encouraging foreign investment particularly in the pharmaceutical sector, with reforms such as the lowering of corporate profit tax from 30 to 25%, and the cutting of reinvestment profit tax from 15 to 12.5%, but the IP and the regulatory environment remain major obstacles as analyzed (TILIOUINE, 2009).

3. Perform internal analysis + external analysis

STRENGHS	WEAKNESSES
_the free medical and nursing high education _pro_health development programs and laws signed by the government to encourage job creation _augmentation of life expectancy in Algeria 71.8 years old in 2020 _ the health insurance system which covers 90% _E-health and software solutions Consumables Hospital waste management Market needs according to All supplies related to Imaging and radiology Importers Diagnostics kits, instrumentation, automates, consumables. Equipment for blood transfusion centers Ophthalmology public and private sectors Dentistry and dental surgery Training for professionals Laboratory instrumentation and consumables. HOSPITAL engineering Occupational health	_the 51/49 joint venture's law that doesn't encourage external investors _lack of healthcare infrastructures and facilities and the urgent need of their rehabilitation _very limited budget is allocated by the government every year comparing to other sectors _staff's incompetence _absence of a control system _failure to revise pricing regulations room for private players.
OPPORTUNITIES	THREATHS
_the oil and gas industry is no longer promising(to opt for a diversification) _the market is still profitable and unexplored yet = opportunities are unlimited for now _digitalization may reduce the charges" through inbound marketing and social media _ the political stability of the country so far _the very high care fees that the public sector requires	_the uprising rate of population explosion _poverty and hunger might be a weakness and an opportunity in the same time _inflation and population's purchasing power deterioration _neighbor countries offering better services" Tunisia" _potential funding problems especially with the actual oil market crisis

_the high cost of other providers which doesn't exactly match with the limited purchasing power in Algeria	–

Figure 6: swot analysis of the internal and external environment

3. Select target audience

- General public: including all its segments

4. Set goals and objectives

- Broad community awareness of public health purpose and services a. Increase perception among the public, policy makers and decision makers concerning the value of public health b. Public health is critical to the public's welfare, therefore resources must be allocated to support public health activities
- Differentiate the health district from other governmental departments
- Draw a distinction between public health, and personal or clinical health service providers
- Specific public health issues identified in the CHIP are addressed
- Strengthen relationships with key organizations, agencies and policy makers
- Promote the use of evidence-based strategies to reduce at-risk behaviors
- Promote brand identity as part of the larger public health system as stated (RICHARD, 2014).

5. Define strategies.

The playbook for hospital and healthcare leadership has fundamentally changed. Integrated hospital systems, freestanding hospitals — no provider is immune from the need to transform its delivery model to align with the Patient Protection and Affordable Care Act

and broader industry reforms. CEOs and their executive teams are tasked with reinventing their organizations to meet the call for a more patient-centric, value-based approach while simultaneously managing traditional, volume-based models

Unilaterally, the CEOs' sentiments echoed what we hear during our daily work with healthcare executives: The healthcare world with which they are accustomed has turned upside down. The primary purpose of hospitals has changed from providing care within their four walls to keeping patients healthy in and out of the hospital.

CEOs must define new strategies for their organizations to succeed. They must establish a cohesive system of care by engaging physicians and improving efficiencies, quality, safety and the patient experience. These demands are forcing them to address their senior talent, as each member must be invested in the process and capable of leading an integrated system.

5-1/Develop action strategies by following these steps

5-1-1/ Horizontal and vertical integration must co-exist. Regardless of a healthcare system's size or complexity, breaking through legacy silos and diminishing traditional fragmentation of care are key to creating a successful integrated and patient- centered delivery model. An initial step is defining "integration," with the leadership team identifying the hurdles a system needs to overcome and defining an iterative change process.

Traditionally, senior leaders have been tasked with oversight of their respective business units and some system-wide decisions. Today's playbook calls for a "team-at-the-top" demonstrating true integration, across vertical and horizontal boundaries of care, both within and well outside of the hospital structure. Moving in this direction calls for the team to develop a shared and clear strategic direction around provision of care. Wrestling with an array of complex issues, including infrastructure requirements, organizational structure, partnerships, efficiencies and culture is central to the job of architecting a delivery system positioned for long-term viability.

5-1-2/The CEO is the primary agent of change. In the past, a CEO was lauded for being an excellent hospital administrator with strong financial and operational acumen. Today, expectations of the CEO are undergoing a material shift.

Contemporary CEOs must be change agents who can win the "hearts and minds" of employees, physicians, the community and a diverse array of stakeholders. A CEO in the new world order must have sufficient vision to fully understand the complex, strategic and practical implications of reform in order to lead the team, transform the organization and achieve new metrics of success.

Building delivery systems focused on access, quality and the patient experience requires alliances previously unimagined or impossible, often extending care across vast geographical regions. The CEO and his or her team must think broadly, entertain unfamiliar and often uncomfortable frameworks, operate well in ambiguity, set a high bar for performance and demonstrate the core values that underlie action. Those CEOs who remain a step ahead will flourish, while those who lag behind will become obsolete.

5-1-3/ Culture is a business imperative. Culture no longer is about the soft side of business. Without the "right" culture, the best-laid operational plans will stagnate in the vertical hierarchy or fail from poor execution. Forward-thinking CEOs are quickly realizing that command and control leadership ultimately breeds mediocrity. Influence is the name of the game in today's era in which patients, staff, physicians and diverse stakeholders must all be engaged to achieve results. To further complicate matters, as hospitals swiftly merge or acquire to remain relevant, conflicting cultures and values may lead to stunted growth and performance.

While wizened CEOs and executive teams are champions of culture transformation initiatives, they also acknowledge that the process is lengthy and difficult.

Accordingly, culture has become one of their top priorities. An increasing

number of hospital CEOs are hiring outside expertise to guide them through a multi-year process of culture change, starting with aligning the C-suite around goals, values, process and commitment. Those experiencing success understand that changing the culture requires ownership by the CEO and full support from all members of the executive team and physician leadership.

5-1-4/A new world calls for new executive skills. CEOs across the country acknowledge that building a care-centric delivery system calls for executives who have a unique combination of both analytical and relational skills. They must be team players, think strategically and operationally, wear multiple hats, and effectively lead and inspire others toward enterprise-wide change.

Analytically, they must understand the dramatic shifts taking place in the industry and grasp the many implications for business and operations. Relationally, they must forge partnerships, establish trust and implement change within the organization and with strategic partners. Sheer intellect, personality and industry acumen are important, but not sufficient for executives who must think systemically and build complicated networks of care.

Many CEOs are restructuring their teams to yield greater impact with fewer people. In some cases, they are accessing talent from other industries to diversify skills and introduce fresh perspectives needed to create a sustainable delivery system.

5-1-5/ Identify and focus on the important. Across the board, the CEOs we spoke with are concerned about the volume and velocity of work everyone is facing. Many are worried that top talent will burn out from the perpetual intensity. As noted earlier, introducing a new playbook while continuing to operate a traditional model of care causes substantial "noise" and diversions to overcome. As a result, CEOs must introduce new practices to ensure ongoing interaction and interdependence among senior team members.

In positioning a hospital for long-term success, the CEO, in tandem with executive leadership, needs to regularly step back to reassess priorities, ensure clear focus and continually ask, "What can we stop doing?" To facilitate time for

reflection, CEOs are holding quarterly retreats with their executive teams to align interests, priorities and sharpen the focus on what is important. Half-day, weekly executive team meetings are becoming commonplace venues to discuss operations and reinforce strategic priorities, culture, metrics and focus on the patient. Concurrently, a similar conversation is taking place throughout the delivery system. Physicians, managers and employees are becoming engaged as everyone pulls together to learn their positions and roles in the new playbook.

"Also these organizations must select partners who share the same mission and objectives mentioned earlier"

- Assign responsible personnel who believe that their job is to lead an orchestra. Expect every member of the executive team to take full personal responsibility to leading change and demonstrating the vision, mission and values. To expect only top performers who fit at the top. If they don't fit, they don't get to stay.
- They need leaders who not only can ensure that 'the trains run on time' but can build and manage a network of care. This requires a different skill set than in the first when focusing on maximizing hospital volume
- The lessons carried from the past are not enough. If we can't learn quickly and change, we're lost
- Provide appropriate control procedures through a listening cell set in every hospital to get the feedback of patients and work on fixing their complaints and adapting the service to the needs of the customers
- The data base which will do the profiling of every patient will help with that too
- So will the accounting service in every hospital because of the targeting process and the personalized service according to the purchasing power of the customers

5-1-6/ Limited and full implementation

The Four Ps of Marketing

The marketing mix is the set of controllable variables that an organization involved in marketing uses to influence the target market. The mix includes product, price, place, and promotion. These four Ps have long been the basis for marketing strategy in other industries and are increasingly being considered by healthcare organizations. However, as will be seen, these aspects of the marketing mix do not necessarily have the same meaning for health professionals as they do for marketers in other industries. (Retrived from https://journals.lww.com/jhmonline/Abstract/1992/01000/Competitive_Strategy_for_Successful_Hospital.5.aspx)

Product

Can refer to goods or services. A good is a tangible product that is typically purchased in an impersonal setting on a one-at-a-time basis.

Services (e.g., physical examinations), on the other hand, are difficult to conceptualize and are intangible in that they do not take the concrete form of goods. For example, if a psychiatric problem is being treated with drugs, the product is easy to specify (e.g., so many pills of a certain dose per day). If the same condition is being treated through counseling, the description of the product is not as precise or standardized (e.g., an unpredictable number of counseling sessions).

In the past, healthcare providers seldom gave much thought to the product concept. A surgical procedure was considered just that and not something that had to be packaged. Today, however, the design of the product, its perceived attributes, and its packaging are all becoming more important concerns for healthcare providers and healthcare marketers.

Price

Price refers to the amount charged for a product, including the fees, charges, premium contributions, deductibles, copayments, and other out-of-pocket costs to consumers of health services. In economic terms, price is thought of in terms of an exchange. In other words, a healthcare provider offers a service in exchange for its customers' dollars. An employee paying an annual premium to a health plan, an insurance company reimbursing a physician's fee, or a consumer purchasing over-the-counter drugs are all exchanges involving a price. The price to the customer could also include the pain, discomfort embarrassment, anxiety, frustration, and other emotional costs of dealing with providers,

plans, and the disease or injury that prompted the experience. An obvious objective of marketing is to convince consumers that they will receive benefits for the price they pay.

Given the manner in which financing is structured in healthcare, price has not historically been a basis for competition. The issue of pricing for health services is a growing concern for marketers as the healthcare environment changes, and a number of factors are increasing the role of the pricing variable in developing a marketing strategy. For marketers, the challenge is understanding what a customer is willing to exchange for some want- satisfying good or service and developing a pricing approach compatible with the organization's goals and cost constraints.

Place

The third P, place, represents the manner in which goods or services are distributed for consumer use. Place relates to all factors of the transaction or relationship experience that make it easy rather than difficult for consumers to obtain an organization's products. Although the obvious factors of location and layout are included, so are hours, access, obstacles, waits for appointments, claims payment, and so on. In most cases, negative place aspects of an encounter impose such costs as lost time, frustration in finding the service site, parking fees, boredom, or other emotional burdens. Positive place aspects usually nullify such costs. For example, when a physician offers early morning or evening hours, patients can obtain care on the way to or from work and thus avoid having to take time off from their jobs.

In some cases, place factors may enhance perceptions of the product's quality, as when the physician's office or hospital is in a trendy location or on a campus that facilitates efficient treatment. Systems or health plans may speed up scheduling by allowing patients to make appointments over the Internet, for example. The online availability of medical records has added a different dimension to the concept of place. Allowing patients to sign up for health plans, check their status, and make benefit changes online at a work-site kiosk or home computer also adds place value.

Promotion

Promotion is the fourth P of the marketing mix. For many people, promotion has historically meant advertising, and advertising has meant marketing. Promotion represents

any way of informing the marketplace that the organization has developed a response to meet its needs. Promotion involves a range of tactics involving publicity, advertising, and personal selling.

Promotion covers all forms of marketing communication and includes materials that deliver content in addition to those that foster transactions.

For example, health plans can devise communications that help new members better understand their coverage, thereby enabling them to use their health plan more effectively. Providers can advise new patients on how to avoid place frustrations and costs, and address symptoms and concerns online before appointments to improve quality and patient satisfaction. The "promotional mix" describes the combination of techniques used by the marketer to achieve promotional goals.

Applying the Four Ps

Many observers find applying the traditional four Ps of the marketing mix to healthcare problematic. Some believe these dimensions of marketing are inappropriate for a service-oriented organization like healthcare. The uncomfortable fit between the four Ps of marketing and healthcare has even led some to pronounce the death of the four Ps and suggest their replacement with some other, more appropriate model in healthcare.

7/Redefine marketing goals and objectives: through strategic alliances (CLEVERLY, O. (1992). Health services administration. Ohio state university.) Retrieved from: https://pubmed.ncbi.nlm.nih.gov/10116113/

Health care organizations, need strategic partners if they hope to be successful, many form alliances with other firms that complement or leverage their capabilities and resources. Alliances, however, are fraught with problems, and many fail.

We here offer some examples of types of alliances. Although alliances achieve common benefit for both parties, they are not merely one company hiring another to perform a service, though both must financially profit from the transaction.

■ Product or service: One organization licenses another to produce its product or service, or two organizations jointly market their complementary service. The most common example in health care is pharmaceutical companies that license their products to firms having a stronger presence in other countries.

■ Promotional: One organization agrees to promote another organization's product or service. Many small pharmaceutical companies use larger firms' sales forces to sell their products. In return, the promoting company gets to augment or complement its own portfolio.

■ Logistics: One organization offers logistical services for another organization's products or services. For example, Abbott Laboratories warehoused and delivered medical and surgical products to hospitals across the United States. In this case, the logistics provider derives a benefit of economies of scale for handling its own products.

■ Pricing: One or more organizations join in a special pricing collaboration. An

HMO can work with a national health club to offer lower rates for their members who sign up with the club. Both can achieve greater market share from this arrangement.

As these examples indicate, health care organizations need to be creative about finding partners who complement their strengths and offset their weaknesses.

Conclusion

The marketing staff must not only develop marketing plans but also carry them out to a successful conclusion. The most brilliant marketing plan counts for little if it is not implemented properly. Consider the following example: After a local hospital learned that patients were not receiving good service from any of the neighboring hospitals, the CEO decided to make excellent customer service its major strategic initiative. When this strategy failed, a postmortem revealed a number of implementation failures: physicians were overworked, nurses were in short supply, nurse call systems were not working well, and the hospital continued to focus most of its attention on cost containment and current profitability. In short, the hospital had failed to make the changes required to carry out its strategic plan. Plans address the what and why of marketing activities. Implementation addresses the who, where, when, and how. As another example, a hospital administrator decided to build a new medical specialty in plastic surgery. To translate this initiative into specific activities and people assignments, the human resources department must compile a list of the best potential department heads for plastic surgery to attract to the hospital; senior management must decide how much they would pay for a leading plastic surgeon; the facilities department needs to assign operating room capacity to support the new service; and the marketing department must decide on how to announce and promote this new service once it is ready to be launched.

It would be useful to keep in mind several points related to the design of organizational reforms. Both the theoretical literature and the real experience in applying these reforms to other sectors point to critical linkages among the important elements of these reforms. Governance reforms must be aligned with each other. For instance, managers given incentives to cut costs must have the ability to alter the use of the key cost drivers, including labor. In addition to being internally consistent, the governance changes must also be aligned with critical elements of the external environment. The design of the governance reforms should therefore take into account key features of the existing

institutional and market environment. As discussed above, the governance reforms must be complemented by the incentives created by existing or new funding arrangements and market structure if strong (and not dysfunctional) incentives for efficiency are to result. The next section will discuss the most relevant aspects of the institutional and market environment in designing these organizational reforms. Following that, we discuss the complementary reforms needed to ensure the maintenance of key sectoral objectives.

General conclusion

General conclusion

It have been better if the qualitative study took place and the determinants of customer satisfactions were really known from the mouths of the Algerian patients themselves, but due to the actual circumstances we contented with the theoretical study and the experiences of foreign countries where healthcare marketing was implemented as a reform of the public sector in order to eliminate bureaucracy and inculcate social justice and that gave some very good results

As for the Algerian case; authorities took all the necessary measures to improve the sector and thanks to the tendency of customer orientation it shall raise for sure "just like the experience of the privatized hospital of DJELFA" run by the Cubans which offers specialized ophthalmological paid services –we fight against gratuity-

As does any company seeking profit and applying the commercial accounting and not the public one every investment and penny spent by the government shall have a result somehow; thus social justice shall be enhanced through customer segmentation and profiling in order to make the appropriate pricing and the most personalized services especially with the fact that more than 90% of the Algerians do own life insurance which is going to make the task easier for the government and for the healthcare staff who shall benefit from an internal marketing formation to put it in the same level as future customers expectations

Paying a formal public health care institution relieves from high satisfaction and way to show contentment, gratitude and a reward for the service quality

Controlling methods shall take place to in addition to the listening cell we have the continuous surveys and data collection techniques

Thanks to the digitalization program which will definitely serve the reform procedure and up raise the Algerian economy through polarization and attraction of funds and capitals previously detoured to neighbor countries and creating new jobs for the graduated students who studied some diversified disciplines in university that will certainly match with the market future needs and become up to date to customers' expectations in order to give added value to the system as a whole

The American experience which quite old comparing to the ours; is considered relatively successful and everything revolves around health insurance and actually Algeria doesn't have a real problem with it

Focusing on complementary services to the healthcare enhances economic development and makes life easier

The reason why I chose this topic is quite obvious; good healthcare service is a priority and Algerian public welfare is the summit of it, through small steps and a humanitarian conscious every good thing shall be reached easily

Limitations:

The main goal of the study was to test the 5 hypothesis and tell what really affects the patients' behavior a field study was supposed to be conducted during the internship but since a pandemic hit the whole country all of this became impossible, in addition to the lockdown that lasted for more than 7 months and the big crisis the affected the means of transport and the all the public facilities and the school campus

Yet we were able to propose a marketing plan at the end of this document which explains and gives details of the reform process and how to reach perfection using internal marketing in every hospital and control each type of flu that goes in and out the institution

The finality of the study was based on other countries' experiences since a real field study appeared to be impossible; with some essential modifications or let's call them adaptations to the Algerian society and its limited purchasing power with all the components of the Algerian lifestyle in order to improve the life level and upraise the public wefare.

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