

Different Buying Behavioural Patterns in the Hungarian Hospital Network

Work-in-progress

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Abstract

The main goal of our research is to better understand the Hungarian hospitals behaviour in their relationship with drug suppliers. The nature of the organisational behaviour guides us to conduct our research on the complexity paradigm (Mucchielli, 2004). To be able to explore the complex procedure of purchasing decisions in the hospitals, we applied a research design based on mixed method research. In our paper we introduce the results of a quantitative and a qualitative research about the business relationships between the hospitals and drug suppliers in Hungary.

Keywords: health care, hospital, behavioural pattern, network

Theoretical background

Business relationship value

We understand business relationships as an interactive exchange activity between two organisations. The business relationship is in the meantime the organisational and management forms of the connections between the two organisations or among the involved people (Mandják, 2004). Our definition is strongly based on the seminal interactive model (Hakansson, 1982) and considers the activities', resources' and actors' connectedness (Hakansson and Snehota, 1995) as the main content of the business relationships. At the same time it means the mutual application of both the resource based and the activity based view (Haanes and Fjeldstad, 2000) of management.

Emerging competence based approaches (Möller, 2006) emphasise not only the crucial role of business relationships but their different character in the point of view of competencies (Golfetto and Gibbert, 2006) and their functions in the value creation process (Möller, 2006). Value creation in different market situations (Haanes and Fjeldstad, 2000; Barney, 2001; Möller, 2006) is considered as the basic task of the supplier-customer relationship.

In this research the value of business relationship is considered as a concept that expresses usefulness and motivation recognised in, or assigned to a business relationship. Usefulness means the economic side and motivation indicates the social side of value (Mandják, 2003; Mandják and Simon, 2007). Usefulness and motivation are value types that determine the value of business relationships. Value types have three levels, exchange, relational and network levels. Each value type in each level is composed by different value constituents.

Based on this business relationship value concept an Integrated Business Relationship Value Model has been developed (Mandják, 2003; Mandják and Simon, 2004) and empirically tested (Mandják and Simon, 2007; Mandják, 2007; Simon 2007). The integrated model of business relationship value describes the usefulness and motivation value types and the value components that constitute these from both the buyer's and supplier's

point of view. It contains indicators at the exchange, relational and network level. The model integrates various sciences' knowledge of value, economic and social value types, economic and social value constituents and value perceptions of the vendor and the customer.

The Integrated Business Relationship Value Model has been used as theoretical and methodological background for this study.

Applying the Integrated Business Relationship Value Model in the healthcare business

The main goal of our research is to better understand the Hungarian hospitals behaviour in their relationship with drug suppliers. Hungarian hospitals are mostly state run institutions and the suppliers are generally directly the national and international drug manufacturers. It means a particular supplier-customer business relationship, where the customer is an institution. "The characteristics, orientations and purchasing process of institutional buyers are somewhere between commercial enterprises and government buyers" (Hutt and Speh, 2007:56). One important characteristic is the determining role of the yearly budget. Sometimes institutions may buy simply because there are some unused funds in their budget, mainly at the end of budgeting period. Buying centres could vary in a broad way, but there are always different professionals involved in them. It means a great possibility of intraorganisational conflicts about and during the buying process (Cochran and White, 1981).

Haanes and Fjeldstad (2000) present their competition level approach on the pharmaceutical industry, stating that big, multinational pharmaceutical companies are generally acting on contractual and operational level competition and generic drug manufacturers are competing at operational level. It seems to be a relevant description for the Hungarian hospital market as well. Drug manufacturers are competing these two levels when they create, maintain and develop a business relationship with Hungarian hospitals.

In a business relationship with drug suppliers the object of exchange episodes are the different pharmaceuticals. We approach the business relationship value from the buyer's side, namely we examine how the hospitals evaluate their drug suppliers. Supplier evaluation is a behavioural question, thus it has economic and social elements. Supplier evaluation is depending on the buyer's purchasing policy and the object of exchange. As drugs are always important but really standardised products the buyer economic behaviour seems to be very similar, what Porter (1985) describes as the Buyer Purchasing Criteria. The value of products is a function of Buyer Purchasing Criteria (Porter, 1985:141-143). Variation in Buyer Purchasing Criteria gives rise to selective adaptation of products or differentiation. Differentiated products can command a higher price if they provide a better match with Buyer Purchasing Criteria. Customer value is defined either by the cost reductions that the product can provide in the customer's activities or by the performance improvements that the customer can gain by using the product (Stabell and Fjeldstad, 1988). Hospitals behaviour must be relatively similar if the purchasing criteria are decisive. Anyway the results of a previous empirical research on that field (Mandjak et al., 2006) show significant differences of the hospitals behaviour in their drug supplier relationships. It seems to be logic that those differences are caused by the social component of the behaviour. Thus in this research we have focused our intention to the social part of business relationship value.

Research background

Social and health care networks are one of the most interesting and challenging research areas of the researchers of the IMP Group (Jarvensivu, Nykanen and Moller, 2007; Mandjak, Simon and Szalkai, 2006). Hospitals as public service producers in most of the countries have special role in the network generally, and the specialities of these actors are also reflected in their business relationships with other actors in the network. Simon, Mandjak and Szalkai (2006, 2008) have reported empirical researches about hospitals' business relationships with drug suppliers in Hungary. Analysing the experienced values of these relationships from the buyer's side (Simon, Mandjak and Szalkai, 2008), they revealed significantly different behavioural patterns of hospitals. These five different behavioural types are formed by the various social value types defined by dissimilar inner importance of the value constituents.

The characteristic of the first behaviour type is the importance of trust based on the frequency of the personal contacts between the participants. This makes the emerging conflicts possible to handle in an efficient and friendly manner. The behavioural method developed together in the relationship makes the reactions of the supplier predictable. The buyer is practically satisfied with the products and services bought in the relationship. The relationship as a whole is more important than the satisfaction with every single product and service in each purchasing procedure.

The second behaviour type is characterised by an unambiguous endeavour to a reliable and good relationship. This behaviour type values a long term, smooth relationship where the buyer is always satisfied with the

delivered products. The frequency of the personal contacts has no significant importance in the relationship. The role of the infrequent but efficient personal contacts seems to be significant, e.g. when they sign annual contracts.

The third behaviour type is characterised by a vigorous endeavour to a reliable relationship, which could be primarily achieved by the frequency of the regular personal contacts. However this relationship presumably could be frequently burdened with conflicts which can be handled or accepted by either with the strong buying power over the supplier or either with the defencelessness of the buyer against its supplier. The fourth behaviour type is characterised by a need for a mutual developed, predictable, potential conflict handling facilitating relationship. The smoothness of the relationship is required by a multilevel, intensive personal relationship. University clinics belonged to this cluster mostly. In the case of the fifth behaviour type, according to the research results, we may say that the economic value components have important role. They are interested in the most favourable offer in each transaction and they do not make any effort for building up long term relationship with the supplier.

The hospital market in Hungary in a nutshell

In Hungary, similarly to other countries, the drug purchase of hospitals represents a relatively small part of the pharmaceutical market. Approximately 15% of the total pharmaceutical sales go to hospitals and this ratio seems to be constant in the last 10 years. We may say that in Hungary, the hospital market became extremely concentrated by now, three wholesaling companies cover more than 80% of the hospitals' drug consumption. Two of the wholesalers are companies with international ownership (one of them is specialized only for the hospital market and its main activity is offering medical services), the third one is owned by the biggest drug producers in Hungary (two of them are also with foreign owners). This latter wholesaler has the unique right to import drugs which are not authorized by the National Institute of Pharmacy. These three wholesalers are considered to be the largest drug suppliers of hospitals in the country. Drug producers with the authority of distribution represent a smaller part in drug distribution to hospitals. This concentrated market results a specific competition, where the relationships of the parties in the network are worth to analyse also from the academic, and also from the managerial point of view.

The subject of this study is to analyse different behavioural patterns through case studies in the Hungarian hospital network. The aim is to reveal the reasons of the differences based on the empirical results of previous studies in this field.

Research method

The nature of the organisational behaviour guides us to conduct our research on the complexity paradigm (Mucchielli 2004). To be able to explore the complex procedure of purchasing decisions in the hospitals, we applied a research design based on mixed method research.

The mixed method research can be conducted in several forms. There can be done a single or multiple study, depending on the purpose of the research or the result of some phases of the research.

This research procedure was designed as a multiple study, where the quantitative data were collected first, followed by the qualitative data collection. Each project is reported separately as a distinct study, but, overall, the program of inquiry can be called mixed methods research. This type of research is often used in large-scale health science projects (Baskerville, Hogg & Lemelin, 2001). There are several arguments why to use a mixed method approach, in our case the ability of this type of research that helps to answer questions cannot be answered by qualitative or quantitative approaches alone. In other case there was the follow-up research question: what explains the quantitative results of the study? So we used the qualitative research to explain the quantitative results (Creswell and Plano, 2007).

As an example of this type of research we should mention the research by Aldrige, Fraser and Huang (1999), where the method was implemented in two distinct phases. The first phase was a quantitative survey, the second phase was the qualitative one with observations and interviews. The authors chose to collect both types of data because they needed to follow up with qualitative information to interpret and explain the initial quantitative results. They identified new questions based on the initial quantitative results and selected cases for qualitative study to answer these questions. The results of the quantitative analysis led them to identify significant differences between the two countries and interesting anomalies in the quantitative data. The qualitative data were used to explain the results obtained in the initial quantitative phase.

Applying the Integrated Value Model (Mandják and Simon, 2007) we examined only those variables, which are relevant from the point of view of the hospital-drug supplier business relationship. We put more emphasis on the social value of the business relationship, but in order to take the usefulness of the relationship into consideration we also put 2 economic value constituents into our analysis, such as:

- profitability of the relationship (relationship level) which is about the difference between the expenses due to the relationship and the savings coming from the relationship for the hospital; and the
- own portfolio management (network level) which is about the importance of the relationship from the hospital's point of view in the hospital's business relationship network.

Among the social value constituents we examined 5 different factors, namely:

- personal relationships (exchange episode level) which describe the personal sympathy with the drug supplier;
- satisfaction with the product (exchange episode level) which means the satisfaction of the hospital with the drugs bought in the relationship;
- smoothness of the relationship (relationship level) is about the routines developed in the relationship with the drug supplier which make it more simple, more transparent and more predictable;
- security of the relationship (relationship level) can be described through mutual confidence, persistence, trustworthiness, probability of keeping a promise and honesty of partners; and
- emanation of the relationship (network level) reflects the reference value of the relationship towards other members of the hospital's network and towards other health care networks.

Each constituent contains several indicators, they have been evaluated by the respondents on a 5-point scale, where 5 means the fully agreement and 1 means the fully disagreement. We tested the reliability of the data with Cronbach-alpha: its value is 0,88.

In the quantitative study we conducted a survey among the chief pharmacists in charge of purchasing in 97 public hospitals in Hungary. In Hungary there are around 100 hospitals with independent organizational drug purchase. The survey was conducted March and April 2009. We sent and collected the questionnaires via e-mail. Finally our sample contained 49 filled-out questionnaires (the survey is similar to the research presented in Simon, Mandják and Szalkai, 2008), that means almost 50% response rate. According to Rea and Parker (1997), in small population studies the sample size ideally should approach the 50% of the population to ensure the most accurate characterization of the population from the sample.

Research findings in the quantitative study

In order to confirm the hypothesis on the relevance of social values and to characterise the relationships on the basis of the social value constituents, we used the method of factor and cluster analysis. For the factor analysis we applied the principal component analysis, all the factors have been selected based on eigenvalue criteria. The KMO value of initial variables was 0.73, the Bartlett's test of sphericity was 337.05 (level of significance 0.000), the total variance explained by the extracted factors was 75%. The results of the factor analysis indicated the correspondence between indicators and the main dimensions (factors) describing the relationship of the hospital and the drug supplier.

Table 1. Factors and variables

	Factors	Variables
F1	Personal relationships	X25, X26, X27, X34
F2	Reliability	X37, X36, X35
F3	Smoothness	X39, X38, X31
F4	Trust	X40, X28, X32
F5	Goodness	X30, X33

For the social values five different factors are identified (F1-F5). These factors combine the original indicators as variables according to Table 1. F1 corresponds to the original value constituent *personal relationships*, F2 refers to the indicators of satisfaction with all the products and services bought in the relationship, the fairness of the supplier and the relationship as a reference for other suppliers, this factor can be interpreted as the value of *reliability*. F3 corresponds to *smoothness* of the relationship, while F4 combines indicators of mutual sympathy, trust, keeping promises to each other and the relationship as a supplier's reference. We call F4 as

the value of *trust*. Finally, F5 combines also various indicators, such as satisfaction with most of the products and services bought in the relationship, the smooth character of the relationship, and the durability of the relationship. We may call this latter factor the value of *goodness*.

We made the segmentation of the hospitals according to the social factors detailed in Table 1. The process of cluster analysis consisted of 2 steps: after the elimination of outliers with the single linkage method we used the Ward method for clustering the respondents. With the help of the cluster analysis we created two major clusters with 20, 16 hospitals, and three minor clusters with 3, 4 and 6 hospitals (based on the F-value criteria we chose the 5-cluster solution for analysis). See the means of the factors in these clusters in Table 2. and Table 3.

The different behaviour types were identified based on a cluster analysis of the examined (49) hospitals (see Table 2 and 3).

Table 2. Characteristics of the major clusters

Factors	Cluster1 (20)	Cluster2 (16)
Personal relationships	0,63	-0,80
Reliability	0,19	0
Smoothness, reliability	-0,12	0,73
Trust	0,60	0
Goodness	0	0,28
TOTAL SATISFACTION	4,35	4,38

Table 3. Characteristics of the minor clusters

Factors	Cluster3 (3)	Cluster4 (4)	Cluster5 (6)
Personal relationships	0,69	0,85	-0,89
Reliability	-2,7	0	0,39
Smoothness, reliability	-0,79	1,01	-1,8
Trust	-0,51	-2,1	-0,52
Goodness	0,19	-0,50	-0,73
TOTAL SATISFACTION	3,67	4,0	3,17

Cluster1 contains 20 hospitals. Chief pharmacists in these hospitals report high importance of the personal characteristic of the relationship. Hospitals in this group are considered to be network oriented, where the social value constituents seem to be important. The relations with the suppliers are tight and go back in the past. The chief pharmacists in these hospitals respect and appreciate the drug supplier, nevertheless they are very satisfied with them (average total satisfaction on a 5-point scale is 4,35). The second biggest cluster contains 16 hospitals (**Cluster2**). According to the respondents in this group the relationship with the drug suppliers is important but not as a personal relationship, but as a requirement for the daily operation of the hospital. Chief pharmacists here seem to be technocrats who consider the relationship with the drug supplier an administrative task. We found almost the same satisfaction grade in the two big clusters (average total satisfaction in the second cluster is 4,38).

The three smaller, or minor clusters may be introduced as outliers of our sample, but regarding the small number of respondents, it is worth examining why they behave so differently comparing to the hospitals in the two major clusters. These hospitals can not be merged into one cluster because of the differences in characteristics, see Table 3.

If we tried to explain the different behaviour patterns, especially in the two big clusters with the so-called “demographic” variables of the hospitals (size, situation, type of decision process etc.), the tests were not significant. If we wanted to find out how the different behaviour can be explained in the segments, we conducted the second phase of the multiple study, a qualitative research.

Findings of the qualitative research

We use interviews as a qualitative method with different actors of the hospital network. We select to analyse hospitals with different buying behaviour types. We made personal interviews with different participants of

the buying center in each hospital clusters: with the chief pharmacist, with the chief physician and with the financial director or the general director of the hospital. As university clinics have unique characteristics compare to other types of hospitals we do not include them into our study (Cluster4). The cluster3 is very small with 3 elements, and is rather heterogeneous, so we consider them as outliers, therefore we did not select any respondent for the interviews from cluster3 or 4. Cluster5 contains 6 hospitals, where we can find some important, key ones, and some elements of behaviour is also very different from the behaviour pattern of the large clusters, therefore we include on representative of the cluster5 into the research.

We made personal interviews with key account managers of a major drug wholesaler and a major drug manufacturer of the hospital market. The interview guidelines reveal the behaviour of the actors in the business relationships. Altogether 16 personal interviews were made.

The demographic characteristics of the examined hospitals are shown in Table 4. We indicate the hospitals involved in the study as *Hospital A, B, C, D* and *E*. The classification of drugs as purchased goods may vary by hospitals which made the determination of the amount of yearly turnover difficult.

Table 4. Characteristics of the examined hospitals

	Cluster1		Cluster2		Cluster5
	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
Number of beds	1869	750	636	160	800
Turnover in year 2008	1700 million HUF	600 million HUF	120 million HUF	250 million HUF	400 million HUF
Ownership	County Government	Budapest City Government	City Government	Ministry of Health	Budapest City Government
Amount of manufacturers' rebate in the percentage of total drug consumption	10%	50%	50%	20%	15%
Key hospital	Yes	Yes	No	No	Yes
Special wards	Yes	No	Yes	Yes	Yes

The method of case study allows of revealing the background of the behavioural types in details. In our research we test the following assumptions:

The different behavioural patterns of the hospitals are depending on

- the structure of the buying center of hospitals, and the power roles in the center;
- the legal obligations concerning the drug purchase of hospitals;
- personal relationships with the drug supplier

Participants of the buying center and their role in the drug purchase

According to the law, in the hospitals, it is the chief pharmacist's duty to prepare the order, to deal with the order and to realize the drug purchase. The selection of drugs to be purchased is assisted by the Committee of Drug Therapy. The Committee consists of the chief physician, other physicians and the chief pharmacist. The order is signed by the chief physician, by the financial director and by the director-general of the hospital. Controlling is responsible for monitoring the drug consumption and the hospital's informatics is also needed to assure the background of the procedure. In case of public procurement, there is an external public procurement expert who takes part in the procurement. This is the general process of signing the contract.

In *Hospital A* and *B* the procedure goes in a continuous, smooth way. The chief pharmacist is responsible for drawing up the list of drugs to be purchased, the financial director sets up the allocation and countersigns the order and the director-general assumes an obligation. In *Hospital C* the chief pharmacist is the one who makes decisions consulting with the physicians about what to order for the hospital wards. In *Hospital D* the chief physician describes his role as a connection between the physicians and the financial director. He exercise control over the physicians' need not to exceed the allocation. If one physician sets up a claim for an exclusively expensive drug, the chief pharmacist asks the chief physician to discuss this need with the physician. But generally he has no deciding role in the procedure.

The process of drug purchase (legal obligations and other restrictions)

The drug purchase of hospitals in Hungary is under the public procurement law. This obligation has deterministic effect on the relationships with the drug suppliers. In our research we planned to reveal the opinion of the participants about the public procurement. In order to control the expenditures for drugs, hospitals usually apply a basic list of drugs and allocation for the hospital wards. The basic list contains those drugs (or effective substances) which are necessary for the everyday treatments in the hospital. This selection of drugs means the basis for formulary management. The Committee of Drug Therapy is responsible for setting up this list on the basis of previous consumption. The list is actualized in every year with the new drugs appearing in the market.

Hospital A and *B* have one-year contract with drug suppliers for public procurement. According to the financial director of *Hospital A* public procurement definitely has disadvantages – time consuming and costly – but it is a well established system in the hospital, and it works correctly. He thinks that the liquidity of the hospital is the influencing factor of the efficiency of the relationship. The financial director of *Hospital B* describes the contradiction of the economic side of the public procurement. While it does not have a direct discount effect, the formulary forces the physicians not to overspend and to use substitution. The chief pharmacist of *Hospital B* declares that professional requirements has not much role in a public procurement. She believes that it has economic advantages because of the competition among the suppliers. It might decrease the cost of purchasing but she has never made a comparison. In *Hospital C* the director-general decided to have a three-year contract in public procurement. According to the financial director of this hospital: “Public procurement has no professional or economic advantage. There are not enough drug suppliers in the market to be a real competition, they take advantage of being so few in number, and they sell the drugs on a higher price if it would be a bargain with him.” In *Hospital D*, decision made by the director general, who did not use public procurement also in the hospital she worked previously. *Hospital E* does not use public procurement, but has stable long term contracts.

All the examined hospitals use basic list of drugs, and allocation for hospital wards as a provision.

Relationship with the drug suppliers, and the role of participants in these relationships

Analysing the relationship with the drug suppliers we have to make a difference between the manufacturer and a wholesaler as a supplier. Due to the central role of chief pharmacists in the procurement procedure, he/she has everyday contact with the suppliers through telephone, fax or e-mail. The other participants have much less frequent and specific relationship with the suppliers. In *Hospital C*, the financial director meets the supplier in contracting and in case of financial problems, when the hospital has default in paying. In this problem solving, the chief pharmacist has a significant role, through his/her personal relationships with the supplier they make a compromise. The representative of the drug supplier may also help in problem solving. The chief pharmacist is present when the financial director meets the supplier’s representative. The financial director does not want to be involved in the relationship with the drug supplier beyond this point. The chief pharmacist is a real “business man” and takes care of the relationship very well, on a daily level.

In *Hospital B* the chief pharmacist could not evaluate the relationship with the major supplier, because she does not make a difference between the suppliers. All the relationships with drug suppliers considered to be the same, always the actual winner of the public procurement tender is the major supplier. There are more than one winner of the tender and the amount of drugs they supply is different. At the decision making process she could not define the word satisfaction, “tender rules everything”- she said. After the order is realized, then the satisfaction means punctuality, invoice and default handling. The supplier relationships with *Hospital A* are considered to be good. Conflicts hardly occur, the suppliers are patient in case of a default paying.

The relationship with the drug manufacturer is completely different. The representatives visit the pharmacist and the physicians in the hospital on a daily level. These visits are mostly about introducing a new drug, or about discussing the prices, purchasing opportunities, and the drug consumption of the hospital with the pharmacist. The drug supply directly from the manufacturers often comes to the hospitals for free. These gifts have role not in the distribution but rather in the marketing policy of the manufacturer. The personal visits of the wholesalers’ representatives are less frequent (on a weekly or a quarterly period) and they visit the pharmacist, or in case of a financial problem, the financial director.

The financial directors has a significantly non personal relationship once in a year with the suppliers, but on a management level, not with the representatives of the firms.

The chief physician is visited by the representatives of the drug manufacturer frequently. In these visits he/she acts as a professional expert, not as a managerial function in the hospital.

Discussion

“Investigation of managed care pharmacy directors’ perceptions of drug cost and utilization drivers indicates that drug mix was perceived as the strongest cost driver of drug expenditures.” (Litton, Faye and Atkins, 2000:810). Regarding the general and finance directors interviewed the cost of drugs is so significant in the limited budget of a hospital in Hungary, that without the high proportion of rebate within the total drug consumption many the majority of hospitals could not survive. The purchased drug can be ordered in two major ways, either through the public procurement or directly from the wholesaler. The role and evaluation of public procurement is different in the different segments of hospitals. It seems to be true, that the larger, more important hospitals do not evaluate the public procurement process as negative, even rather as a positive method for getting better prices and offers. We should assume that at the case of large, key hospitals their power helps them to achieve better offers, so they can use the advantage of the standard process. In contrast to them the smaller hospitals or the hospitals with special needs do not have enough power or volume of orders, so they can not achieve the same favourable conditions, so they do not find this type of purchasing as very positive that could provide financial or other advantages. On the other hand the special needs do not fit in the standard offering structure of the public procurement procedures.

The other factor that will be regarded in a different way in the key and smaller, rather special hospitals is the contacts, the relationship with the suppliers. The perception of contact is quite different in the first and second cluster, as the hospitals in the second cluster do not regard the daily ordering contacts as relationship with the representative of the supplier company.

Conclusion

The results of previous studies (Mandják, Simon and Szalkai, 2008) show that demographic (e.g. size) and geographic characteristics of hospitals may not consider to be the reasons of the different buying behaviour types. With the help of the mixed research method we managed to go beneath of these differences. We assume that the results will have managerial implications for the actors of the network in the future.

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