CHAPTER 1
INTRODUCTION

1.1 Scope and objectives of the study

It is acknowledged and agreed that organizations’ sustainable competitiveness emerges from innovation (e.g. Bowers and Khorakian, 2014; Alegre et al., 2013; De Brentani et al., 2010). According to Blumentritt et al. (2005), who conducted research on how entrepreneurs form internal cultures that may generate innovative activities, incessant innovation entails incorporated organizational systems and procedures to guarantee development. From an entrepreneurial aspect, Simmons et al. (2009) allege that entrepreneurship generates value using innovation, seizing new business openings. Likewise, Audretsch and Walshok (2013), and Audretsch and Link (2012), whose study focuses on entrepreneurship and innovation, stress that entrepreneurship means turning simple ideas into marketable products or services. There are only a few remarkable studies available regarding new service development in the healthcare industry: Avise et al., 2014; Ennis and Wykes, 2013; Mockford et al., 2012. Moreover, Nambisan’s study (2002, p. 394) contends that customers are an outstanding source of innovative ideas in many different markets and situations (a view supported by Korschun et al., 2014; Witkowska and Lakstutiene, 2014). In addition, Tobin et al. (2002, p. 93) declare the significance of communication and building bonds with patients, stating: “the opportunities for consumer participation occur first at this clinical interface in terms of what information is transferred, in what direction, and in how the communication takes place. Nurturing participation at this level has a fundamental role in consumer empowerment.”

The notions of entrepreneurship and customer-orientation are both extremely significant in the healthcare industry. However, there only exist a few papers that have studied the above-mentioned topics. This research concentrates on the health service industry, by probing into the principles of demand and offer governing mental healthcare services in Northern Greece. Lately, the industry in question has undergone significant change due to mergers of organizations that operate in the three wider sectors (general clinics, obstetrical and gynecological clinics, and diagnostic centers). This development has led to healthcare
groups’ expansion and the provision of a wide range of diagnostic and treatment services. The growth of the private healthcare market has amplified the competition between organizations, which make efforts to provide high service quality, promptness, and modern facilities. Moreover, a remarkable improvement in the field of mental health services decentralization has been noticed, as far as it concerns the mental healthcare sector (Madianos et al., 1999b). However, there are more steps that need to be taken for the further enhancement and provision of mental healthcare services. In addition, since the mental health service industry is not substantially developed, only a small number of independent private hospitals exist in Greece, although patients’ needs and requirements do not seem to be fulfilled by public mental health hospitals. Comprehensive information on this topic can be found in Chapter 3.1.3.

The purpose of the present study is to investigate the influence of user involvement on new service development and how outcomes of this can enhance a firm’s entrepreneurial activity. On one hand, the aim of this study is to advance previous service-innovation theory by associating it with entrepreneurship theory, while, on the other, it seeks to extend previous knowledge regarding the benefits of customer participation in new health service development. Section 1.2 below analyses some key theories on entrepreneurship and organisational growth and service development and customer involvement, discussing the research gaps in these fields, and presenting the focus of the study. Apart from theoretical propositions concerning service innovation opportunities, business development, and service user implication in innovation processes, this study also involves significant managerial propositions that concern the input of hospital executives and medical staff on hospital operations, growth, and sustainability in mental healthcare. In particular, the outcomes of this study present an accurate depiction of mental health services delivery within the case hospitals, as well as the strategies that should be followed to create and implement services that will be adjusted to patients’ real needs. This kind of action could give mental healthcare organizations essential competitive advantages and chances to develop their mental healthcare services.
1.2 Theoretical foundation and research questions

Having evaluated the research framework and theoretical setting of the examined topic, so as to identify the deliberate breaches and the crucial issues in the Greek healthcare industry, and especially the private sector, the researcher composed research inquiries regarding these cognitive gaps and the solution of critical issues.

1.2.1 Corporate venturing and customer-driven service innovation

The framework (Figure 1.1) presents a synopsis of the key theories that served as a foundation for this research. Four theoretical concepts were taken into consideration: theory of service innovation (e.g. Carlborg et al., 2014; Fox et al., 2014; Salunke et al., 2013; Cheng et al., 2012), theory of customer involvement (e.g. Korschun et al., 2014; Witkowska and Lakstutiene, 2014; Grissemann et al., 2013; Lee et al., 2011), and corporate venturing and organizational growth (e.g. Wei et al., 2014; Efrat, 2014; Battistini et al., 2013; Dokko and Gabba, 2012). Each of these concepts is thoroughly analyzed separately and about one another in the following sections of this study.
A great number of authors (e.g. Smith et al., 2007; Tidd and Hull, 2003; Day and Wensley, 1988; Storey and Easingwood, 1999) focused on the topic of sustainable service innovation. They describe service innovation as the most beneficial method that firms can apply to attain enduring success and organic growth (Melton and Hartline, 2010). Another suggestion supports that service companies can accomplish higher levels of success by adopting customer-centered perspectives (Sing Wong and Tong, 2012; Svendsen et al., 2011; Ottenbacher and Harrington, 2008). Greer and Lei’s (2012, p.63) recent research amplifies the aforementioned perception, as it concentrates on the ways by which firms assume collaborative innovation with individuals and customers and deduces, “Collaborative innovation with customers or users is increasingly important for the development of new products and services.” Similarly, Rehme and Svensson (2011), combine entrepreneurship and marketing theories to elucidate the approaches applied by new ventures for the achievement of key landmarks. They obviously amplify the above notion claiming that “firms that involve customers or users in their product development processes are more likely to succeed in the
market than firms that do not at an early stage receive feedback from users, and direct customer involvement in the development of their offering is likely to increase revenues with a guaranteed sale, making it necessary for them to have a strategic view on customer involvement” (p. 6). Likewise, research conducted by Jenssen and Aasheim (2010) discusses the influence of organizational factors on innovation and performance in knowledge-intensive firms, stating that a successful product development relies on the level of market contribution to the development process. This perspective is also supported by Carbonell et al. (2011) who argue that customer involvement adds to service advantage and speed to the market while lead user contribution enhances the degree of novelty of new services and service position although it negatively influences market performance. As opposed to Carbonell et al.’s conclusions about market performance, Kandampully’s study (2002) argued that the marketplace is directed by new services that aim at developing customers’ needs. Another research, which emphasizes customers’ significance in service implementation concluded that “the value that consumers provide derives from their use of services in day-to-day life, which makes their experience and knowledge pertinent, particularly for increasing market acceptance of new services, improving services, identifying market trends early and providing a source of new ideas” Jiménez-Zarco et al. (2011, p. 57). Alternatively, some studies underline the insufficiency of research concerning the interaction between innovation and entrepreneurship (e.g. Zhao, 2005a; McFadzean et al., 2005; Littunen, 2000; Hornsby et al., 2002, etc). Zhao (2005a, p. 25) declares, “The combination of entrepreneurship and innovation holds the key to organizational sustainability,” adding that the synergy between two concepts contributes to firms’ viability and prosperity within this changing environment (Zhao, 2005a, 2005b). Similarly, Kelley’s (2011) research, whose aim is to describe how traditional firms can include new business activities in their procedures, correlates entrepreneurship with innovation, as well as innovation with the opportunity of boosting companies’ competitive features, offering exceptional value to their customers. This viewpoint is by the outcomes of De Burcharth and Ulhøi’s (2011) study, which probed into unconventional organizational ideas to induce radical innovation, contending that radical innovation usually results from new entrepreneurial ventures. However, Hinz and Ingerfurth (2013), and Sundin et al. (2012) discovered that healthcare companies face the risk of not being able to discern their strategic, financial, and operational goals and, thus, generate improper types of new business ventures.
Taking into consideration the disputed topics in the above-mentioned theories; the present research aims to examine the relation between entrepreneurship, innovation, and organizational development in a real business framework in the healthcare sector by observing if novel business openings are adequately exploited towards fulfilling firms’ needs for development and patients’ requirements for quality treatment. Therefore, this study follows a precise sequence of discussion that results in the development of its conceptual framework (see Chapter 4). Four main concepts constitute the theoretical framework, which also discusses the motives that impel healthcare companies to apply innovation as well as the entrepreneurial and new service opportunities that stem from the combination of service innovation and corporate venturing and, additionally, of new service development and customer orientation. These central concepts, having been derived from other disciplines and study fields, have been mostly useful to include in this study so as to comprehend their impact on the Greek healthcare market. Sections 4.4 and 4.5 of Chapter 4 thoroughly examine the rationale for incorporating each of these determining concepts into the formation of the conceptual framework. The following section refers to the underexplored research fields, intending to attend to the theoretical limitations by dealing with the topic from a viewpoint that associates the concepts of innovation, entrepreneurship, organizational development, and customer implication in new service development.

1.2.2 Theoretical limitations and research questions

Few studies, out of those having treated the subject matter of service sectors and, more precisely, service innovation, have investigated the healthcare industry and, more specifically, mental healthcare (Kelly et al., 2012; Bellou, 2010). Moreover, a small number of studies have concentrated on customers’ input and implication in the development of novel health offerings and, much less, in the establishment and application of new mental health services (Ennis and Wykes, 2013; Thompson and McCabe, 2012). Finally, there is a complete lack of studies that focus on and analyze the expansion and sustainability of a healthcare organization from two distinctive viewpoints. One of them is service innovation and its ability to induce exploitation of entrepreneurial opportunities, and the other is customers’ inclusion in new service development as a tool for the aforementioned expansion and, therefore, for the accomplishment of a firm’s sustainable development. The researcher, having reviewed the
research context and theoretical studies regarding the Greek healthcare system, has formed the following research questions.

The healthcare sector is dominated by the concept of innovation; there exist health organizations, which play a leading role in innovation, introducing daily new cures and technologies (Groene et al., 2014; Shortus et al., 2013). Nevertheless, this fast pace of change can often repress firms that do not dispose of the means to stay updated and adapt to these speedy changes, and, therefore, wind up experiencing business inertia (Rohrbeck and Gemünden, 2011). Other possible complications that innovation in the healthcare industry entails can be attributed to the bureaucracy and other related problems, such as official procedures, concerning the industry in question (Bellou, 2010; Duncan and Breslin, 2009). Attempts to improve such complications and issues have been presented by a number of studies (e.g. Staniszewska et al., 2013; Menor and Roth, 2007; Nijssen et al., 2006) which propose a strict, systematic approach to new service development as being able to establish a more efficient strategy that leads to successful innovation. Besides, some theoretical works have emphasized the significance and the essential role of customers and of the market in general in fruitful service innovation, highlighting that the level of innovation relies on the cooperation and the interaction between clients and producers as well as on the development of a new value system among the business partners (market orientation) (e.g. Den Hertog et al., 2010; Agarwal and Selen, 2009). In this context, the research question that follows intends to study customers’ role in the examined organizations’ innovation strategy. This will provide the researcher with information about the extroversion or introversion of the examined healthcare businesses and it will also assist in comprehending whether these organizations appreciate customer involvement:

**RQ1:** Where, how and why should patients be involved in new service development?

The activities aiming at the development of new services are considered to be imperative because they reinforce current business and generate the possibility for new business ventures (Papastathopoulou and Hultink, 2012; Jin et al., 2010). The need for new service development is particularly significant in the health care market due to the character of the services offered. A study by Smith et al. (2007), which described five different models regarding the planning and implementation of new healthcare services, discovered that the
success of a health services development process requires the accordance among three crucial parameters; the service design, the organization’s objectives and strategies and the stakeholders’ interests and expectations (government, health board, etc.). It is also commonly accepted that customer-centered companies enhance customer satisfaction and provide a higher quality of services (e.g. Korschun et al., 2014; Blocker et al., 2011). This element is particularly related to the healthcare industry since health services should be adjusted to individual patients, balancing their needs to be effective (Berry and Mirabito, 2010). Besides, increased customer orientation appears to affect doctors’ working practices and their sense of professionalism (Staniszewska et al., 2013; Cohen et al., 2004). Furthermore, Rademakers et al. (2011) pointed out that the objectives of implicating patients are to promote health results, increase satisfaction and cut down on cost.

The fact that customers can now access more directly information concerning healthcare is another significant point, which has contributed to transforming the present healthcare experience from purely procedures and services, to an integrated process that begins before admission and lasts until after discharge (Rademakers et al., 2011; Ford and Fottler, 2000). Therefore, executives should think of fruitful ways to offer healthcare services. Rise et al. (2013) mention in their study that healthcare organizations should focus on new techniques, such as customer orientation, to accomplish patient satisfaction. This point recalls the findings of Bowers (1987), and recently of Robertson et al. (2014), which declare that both internal and external implications are necessary for developing new service ideas, which then should be assessed by therapists, doctors and service users. Similarly, Windrum and Garcia-Goni (2008) created a framework for innovative health service development that includes policy makers and service providers as well as companies and service recipients. They underlined health professionals’ competencies, and their interactions with patients, reporting that those define service features. However, it was clarified in the review of the literature that hospitals concentrated more on their medical personnel’s and third-party payers’ expectations than on their customers’ needs (e.g. Rise et al., 2013). Additionally, the studies of Groene et al. (2014), and Gafni and Whelan (1997) indicate clinicians as the “perfect agents” for their patients, and other theoretical works have proved that there still exist medical and nursing staff who claim that mental health service recipients do not have much to offer to decision-making and new service development procedures (e.g. Bennetts et al.,
The aforementioned points result in the question whether the medical staff is compliant with implicating patients in this type of processes and in what ways they would affect the firm’s decisions if the hospital’s managers decided to take steps by asking patients to be part of its innovative initiatives. The research question below intends to investigate medical staff’s perceptions regarding customer orientation, since no clarified conclusion exists in the literature as far as it concerns their contribution in the implementation of patient-centered services:

**RQ2:** How do medical personnel perceive patient involvement in new service development?

Recently, mental health care service recipients have undertaken more significant action in their cure and hospitalization procedures. The studies of Tambuyzer et al. (2014), and Shortus et al. (2013) pointed out that until the early 1980s, mental health service users were passive recipients of their treatment and did not participate nor affect considerably the services they used. The World Health Organization (1990) recommended that patients should be implicated in the decision-making process that concerns their treatment; however, it has been mentioned in the literature that psychiatric patients have not been treated with equal thoughtfulness as other types of patients (Bellou, 2010; Lammers and Happell, 2003). Many changes have taken place since the 1980s that have contributed to mental health patients’ increased influence over the services they use, including patients being able to control more profoundly their treatment and the decisions involved, and a more detailed briefing regarding the types of treatment offered. This change can prove that mental health patients possess a crucial positioning in service development, specifically in mental health care contexts. As a result and according to some studies, there exists a breach in the literature about the way psychiatric patients should participate in new service development (e.g. Bennetts et al., 2011; Davies et al., 2009). The following research question aims to explore medical staff’s contribution to the development of patient-oriented services in mental healthcare, as there is no clear picture in the literature about their role in the development process:

**RQ3:** What is the role of medical personnel in patient-oriented service development?
Moreover, corporate entrepreneurship and venturing are considered to be organizational capabilities that induce entrepreneurial behavior within organizations so as to surpass internal restraints, confront bureaucracy, and promote innovation via novel business schemes (Evald and Senderovitz, 2013; Salvato et al., 2009). This concept often correlated with competitive achievements and is known to be attained using some methods. Likewise, Kraus and Rügtering (2010), who reckon corporate entrepreneurship as a company philosophy, state that corporate entrepreneurship is a strategy which enhances companies’ innovative competence and increases employee satisfaction. A specific feature of corporate entrepreneurship, corporate venturing, is described by theoretical works as a crucial concept in organizations’ strategic planning that aims at developing innovative schemes and gaining competitive advantages and, thereby, accomplishing organizational sustainability and long-standing expansion (e.g. Korsgaard and Anderson, 2011; Narayanan et al., 2008). Other studies have also cited that corporate venturing contributes to amplifying a firm’s intention to innovate, and employees seem to play a significant role in both innovation and business growth (Titus et al., 2014; Guerrero and Peña-Legazkue, 2013). After having reviewed these arguments, the researcher intends to investigate using the following research question an unexplored field in the mental healthcare context:

**RQ4:** How and to what extent is corporate venturing developed by adopting service innovation initiatives?

Overall, the interaction between innovation and entrepreneurship has not been analyzed extensively in the literature (Brem and Borchardt, 2014; Belz, 2013; Carayannis et al., 2013). Some researchers attribute this to the aforementioned concepts’ definitional vagueness (De Burcharth, and Ulhøi, 2011; Dunlap-Hinkler et al., 2010; McFadzean et al., 2005). Furthermore, only little research has been conducted regarding the topic of customer involvement in the new service development process (Edvardsson et al., 2012; Field et al., 2012). The present research stresses the remark that, even though the healthcare industry is an outstanding case of an industry with a horizon of opportunities to explore regarding innovation and new service development, it still is an underdeveloped area of research. Insufficient research is specifically obvious in the mental healthcare sector that, however, imposes the need for customer implication in new service development. Although mental
health service recipients play an important role in the service development process, their preferences and capabilities have not been thoroughly investigated. In addition, the researcher has figured out that another concept that remains an underexplored research area is this of entrepreneurship in the healthcare industry. Therefore, it would be necessary to discuss how healthcare providers choose to develop new business ventures so as to provide new service offerings.

1.2.3 Brief introduction to the Greek healthcare sector

Initially, the public sector’s inefficiency is a vital issue, which can be associated with some other complications as well, such as structural setbacks of the Greek NHS, which can be mainly defined as deficient infrastructure, lack of technological progress, and insufficient medical and nursing staff. The improvement of living standards, the gradual aging of the population, the emergence of new diseases, and people’s observed orientation trend towards selecting private insurance plans are factors that lead to the gradual rise in demand for private health services and preventative medicine. Furthermore, the progress of medical science along with the technological advances in the healthcare sector, generate increasing demand for direct, more efficient and higher quality health services. Usually, private health service firms consist of big companies, which are robust and knowledgeable in the healthcare sector, where the competition is extremely intense. For this reason, it is not easy for a newly established company to set foot in the private health service industry because of technical and economic restraints. The current institutional status quo sets certain impediments to the development of new companies in the industry, such as certain conditions and construction specifications that stakeholders consider remarkably severe. Recently, the industry has faced significant changes as a result of mergers and acquisitions between companies in the sector. A consequence of this trend is the predominance of multi-purpose medical service business groups, which provide a wide variety of diagnostic and treatment services. Competitiveness between private health enterprises has been remarkably strong in recent years and concentrates mainly on the replacement of medical equipment, as well as on the range, quality improvement, and velocity of services offered. Finally yet importantly, it focuses on the network expansion (presence in more areas) and cooperation with insurance funds.
Moreover, long-standing development of the total domestic private health services market (in value) has been observed during 1998 – 2012. Also, its size stood at €1.985 million in 2012, compared to €574 million in 1998, representing average annual growth rate 13.2%. Furthermore, health services are directed to individual consumers; thereby, their bargaining power is restricted. Nevertheless, the opinion of a patient’s doctor, always in conjunction with that of the insurance company (if one exists) and, certainly, a good comprehension and perception of the market may direct them towards opting for the most inexpensive solution in the framework of their needs and demands. Furthermore, the rising number of migrants who are not able to afford private health services has resulted in overcrowding in public hospitals; this parameter directs part of the demand to the private sector. Largely, the share of private participation in total health expenditure was estimated at 37.07% in 2012. The latest available Budget Report of NSSG (National Statistical Service of Greece), in 2011/12 indicates that total monthly healthcare costs all over Greece reached an average of €128.17 per household, covering 7.2% of overall monthly costs for each type of goods and services.

1.3 Research approach and methods

Qualitative research has been carried out taking into account all the above-described points, and the findings of Rohrbeck and Gemünden (2011, p.234), who claim, “for research fields that are relatively new and about which the knowledge is limited, qualitative research design is recommended.” The study was conducted in two research phases, where each one of them emphasized the subject matter to be examined. The first one comprised comprehensive and influential interviews with higher executives and managerial personnel of the case hospitals. It aimed at exploring issues concerning innovation, entrepreneurship, and customer orientation from the perspective of management. The second phase consisted of semi-structured investigative interviews with selected medical personnel of each health institution with the aim to delve into issues about patients’ implication in services’ implementation from a medical aspect. The principal objective was to achieve a deeper perception of their points of view and, thereby, a comparison with the opinions of other stakeholders.

Despite the fact that each section of this research is autonomous, the coexistence of the two sections grants detailed and fruitful information from different perspectives. This
information was combined, correlated, and juxtaposed, generating responses to significant questions: such as how patients should be included in service development, what is the role of customers (and of the market) in health service development, and what the viewpoint of medical personnel is as far as it concerns customer orientation, as well as what role they play in implementing customer-centered offerings. Thus, the opinions of all kinds of stakeholders are profoundly valued with respect to the development of innovative patient-oriented healthcare services and utilization of business openings using corporate investments. The interviews, in all phases of the research, were carried out during the period of November 2014 to January 2015. Provided that the present research was conducted via open and fact-finding interviews, all sections of the research applied the same qualitative analysis process. Content analysis is used in this study as a replicable and valid method leading to specific implications from text to other states or properties of its source (Krippendorff, 1969). Conventional content analysis is preferred in healthcare research as a method to code categories deriving directly from the participants’ responses (Hsieh and Shannon, 2005; Graneheim and Lundman, 2004). The principal purpose was to identify, explore, and further contrast the data compiled from all kinds of participants to achieve accurate and constructive responses to the research questions (Brown and Lloyd, 2001).

1.4 Novelty and contribution of the study

A number of critical studies in the innovation and entrepreneurship field highlight the dynamics between, not only corporate entrepreneurship and innovation but also innovation and the ability to enhance an organisation’s competitive positioning and to provide outstanding value to its customers. For instance, Autio et al. (2014), Tidd et al. (2005), and Bernstein and Singh (2006) have thoroughly discussed that innovation contributes to organisational competitiveness and market success, identifying gaps in the theory as to the ways in which organisations exploit current resources and potential opportunities to gain competitive advantages and achieve long-term growth. Likewise, a lack of research has been identified regarding the synergy between innovation and entrepreneurship, noting that the synergy between the two concepts helps organisations to prosper. This theoretical gap was identified by Bao et al. (2012), and Brem and Borchardt (2014), who recognised that the entrepreneurial innovations (e.g. new units of healthcare to satisfy unmet needs) are
considered as resilient strategies and powerful methods for organisational survival and corporate competitiveness. Similarly, Sing Wong and Tong (2012), Svendsen et al. (2011), and Ottenbacher and Harrington (2008) argue that continuous service innovation is among the most valuable means for companies to achieve long-term success and organisational growth. It is also suggested in the literature that for service firms to achieve even greater success, a customer-orientation perspective should be adopted. For instance, Rehme and Svensson (2011), combine entrepreneurship and marketing theories to illustrate the approaches that new ventures employ to achieve key milestones, arguing that the companies that involve customers in the innovation processes have better chances to succeed in the market. On the other hand, Windrum and Garcia-Goni (2008) and Lerro et al. (2012) argue that users’ preferences and competencies determine the characteristics of the service offering, therefore their participation is critical. Although some studies concerning the service sectors and in particular service innovation have been carried out, they have rarely been conducted in the context of healthcare, and in particular, that of mental healthcare. In addition, few studies have focused on the interaction and involvement of patients in the development of new health services.

Consequently, it becomes apparent that the dynamics of and interactions between corporate venturing and organizational growth, and service development and customer involvement in new service development are highly related to each other, leaving a number of theoretical gaps that remain unexplored. This study addresses important questions raised in the above and other studies about cooperation dynamics, entrepreneurship and innovation that is likely to emerge from innovation initiatives that adopt customers’ suggestions, aiming at addressing social challenges. In particular, this study contributes to the literature of service innovation and corporate entrepreneurship by examining and considering the role of individual actors in the exploitation of business opportunities through the development of customised new offerings and through the emergence of knowledge-based interactions among partners. This thesis provides evidence that firms should identify and consider practical ways to manage innovation initiatives - both at an organizational level and at the individual and team level -, to maintain their competitive advantage. Based on this, an important implication - which is described as a research gap in the studies of Autio et al. (2014), Efrat (2014), Groene et al. (2014), Mahr et al. (2014), Robertson et al. (2014), and
Guerrero and Peña-Legazkue (2013) relates to the mechanisms by which innovation is developed and diffused within the organization, among different entities and across boundaries, verifying that entrepreneurial activities help firms satisfy customers’ demands. Additional discussion regarding the contributions of this study, especially in the field of mental healthcare can be found in subsection 8.3.1.

Considering the value of this thesis, we see that the findings of this research can be beneficial to several groups. The table below (Table 1.1) depicts this study’s input, which has been partitioned into two parts according to their respective theoretical, practical, and pedagogical functions (see chapter 8).

**Table 1.1 Contributions of the study**

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<th>Contributions of the study</th>
<th>Beneficiaries</th>
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<td><strong>Theoretical contribution</strong></td>
<td>Researchers in the fields of service innovation, customer involvement in service innovation, corporate entrepreneurship and venturing, organisational growth</td>
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<td></td>
<td>Mental healthcare sector in Greece</td>
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<td><strong>Practical contribution</strong></td>
<td>Strategic teams and hospital executives of the examined organisations</td>
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<td></td>
<td>Doctors and other medical staff of the examined hospitals</td>
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<td>Conceptual framework</td>
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<td>New business development model</td>
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In theory, this research assumes a critical approach of the concepts of innovation and entrepreneurship ventures in the mental healthcare industry, contemplating multiparty business enterprises, knowledge and expertise diffusion, initiative allocation to several agents, power allotment and research evidence. Along with the development of a conceptual model for innovation in mental healthcare services, the necessity for change in organizational ethos and the techniques for the development of service recipient initiatives are taken into account. By adopting a case study approach, the strategies followed by the case hospitals for market growth and leadership are investigated and, are, then, associated with the organizations’ internal structure. The already existing as well as up-and-coming chances for business expansion are spotted by board members, shareholders, managerial staff, and medical and nursing personnel. Each of these agents contributes decisively to companies’ entrepreneurial and ambitious mission statement. The data analysis renders obvious the fact that the examined healthcare firms comprise dynamic and creative management teams that
have the ability to retrace business expansion opportunities and venues. They have also demonstrated a substantial awareness of the particularities of the local markets and have customized their corporate plans so as to attend to local needs. Currently, they seem to be in the process of establishing solid partnerships with public institutions, exploiting chances for fundamental innovation. Simultaneously, the issue of organizational culture’s impact on strategic decisions exists. The fact that the majority of Greek organizations apply a hierarchical management approach makes it improbable for the examined healthcare companies to approve mental health service recipients’ involvement in the business development process. Therefore, it is noteworthy to discuss the attitudes and perspectives at several layers of management and authority within the organizations and associate these with the organizational structure of the examined healthcare units. Obstructions are remarked within the corporate culture and a new concept of innovation is shaped so as to comprise opportunities for new partnerships, patient-focused services, and business development. The argument for embracing new attitudes that can lead to more flexible and adaptable structures and a complete healthcare offering is developed.

The present thesis re-examines the relevant theoretical works and creates a framework, which inspects the level of service user implication needed to achieve a flourishing new service development; it also investigates how these new offerings can assist newly established and growing mental healthcare organizations. Thereby, this study’s aim is to explore the impact of customers’ inclusion on the development of new services, as well as to discuss the methods using which the result may improve a company’s venturing activity in the world of the healthcare market. This research attends to the need for further development and study of the concepts of customer participation in the new service development procedure and, also, of the association between innovation and entrepreneurship (e.g. Autio et al., 2014; Mahr et al., 2014; Witkowska and Lakstutiene, 2014). Furthermore, it seeks to apply the concept of entrepreneurship to the developing field of service innovation. The principal outcome of this research is the development of a conceptual framework, which presents how new service development can add to corporate business activities. More precisely, the conceptual framework conceived in this research adds to the existing service development literature by providing directions regarding how to explore the ways in which hospitals implement offerings that respond to patients’ needs; it also provides guidance on
identifying and exploiting new business openings. Moreover, this study enriches the
discussion on customer-oriented new service development. Since customer involvement in
new service development is a quite new field of research, only a few authors have investigated
its looming issues or the benefits that can result from it (Grissemann et al., 2013). The present
study is one of the first to include this concept in the healthcare field of research.

The present study underlines and analyzes the link and connection between
innovation and entrepreneurship, and it applies, for the first time in the record of related
literature, this theory and analysis to the healthcare industry. In addition, it has been deducted
that the success of healthcare organizations depends on following service innovation
techniques that will enable them to identify new business opportunities. The study’s
conceptual framework contributes significantly to innovation and entrepreneurship research
since it creates a new approach towards tracking new business opportunities via customer-
centered new service development more systematically than it had been put into practice
before. In essence, this study contributes to the strategic and operational context of the
mental healthcare institutions in Northern Greece. Suggestions made by members of
management teams include, at first, the application of service development processes, which
will be well-planned, coordinated, and implemented in ways that serve quality and innovation
so as to foster the chances of progress and success. Also, it becomes obvious that the case
hospitals are deficient in proper business culture and organizational structures since there is
limited cooperation between the management teams and the medical staff. Moreover, it is
important for the hospitals to adopt an entrepreneurial attitude, which would rely on the
existing organization, enhance the internal business environment, and promote effectiveness.
Furthermore, they should reflect on implementing innovation projects, follow procedures,
and take advantage of resources that could promote innovation activities, increase new
business openings, and enhance competitiveness. Finally, it seems that the majority of the
case healthcare firms’ management teams think of patients as a fruitful source of
enhancement and evolution of the already offered residential services; however, they have
yet to apply procedures that will involve patients in the new health service implementation
process. Thus, they should contemplate integrating service recipients in their development
activities so as to design and generate services that satisfy customers’ needs and demands.
Consequently, it is recommended to apply approaches and implement practices that enable
companies take customers’ viewpoints into account and, thus, to accommodate the offer of services that are adapted to patients’ requirements and needs.

1.5 Outline of thesis

This study consists of eight chapters, which are briefly described below. Figure 1.2 illustrates the structure of the research. The first part of Chapter 2 reviews the literature and theories of service innovation, entrepreneurship, and corporate venturing. Specifically, it defines service innovation, highlights the importance of service innovation strategies, and identifies related processes. Furthermore, it focuses on entrepreneurship and its types and portrays the dimensions and characteristics of corporate venturing. The second part of the chapter explores the literature and the theories of both new service development and customer orientation. It defines new service development and presents the types and characteristics of, and critical factors for new service development. It also illustrates the strategies and the processes of new service development, with an emphasis on models for health service innovation. The chapter also defines customer orientation, underlining customer roles in service innovation and customer involvement in the healthcare industry. Lastly, it points up the processes for customer orientation development. Chapter 3 focuses on the healthcare market, considering both the demand and provision of healthcare services in Greece. In particular, it encompasses general information on the Greek healthcare industry, such as the structure of health services in Greece, the characteristics of the industry, health expenditure, and an overview of the mental healthcare system in Greece. This chapter includes the characteristics of and the factors affecting the demand for private health services, as well as the development of its infrastructure and industry structure; the conditions of competition, and a description of the private healthcare market in Greece in terms of domestic market size. Finally, it includes brief profiles of the case organisations.

Chapter 4 combines the theories of both corporate venturing and innovation and customer involvement in new service development. It stresses the relation between corporate venturing and service innovation and illustrates the models that combine the two terms. It also draws attention to the importance of customer participation in new service development activities. Finally, it develops the conceptual framework for new service development through
Chapter 6 investigates the operation of the five case mental health hospitals, examining the views of both administrative and medical staff regarding the factors that determine innovative activity; the tools and the processes applied to new service development; the contribution of customers and the role of executives and medical personnel into the innovation process and; the customer involvement in new health service development. Chapter 7 summarises the main findings of the two phases of the research and includes a cross-case synthesis. Lastly chapter 8 includes the evaluation of the research findings and considers the contribution of the research to the subject of study. In particular, the discussion relates to innovation and corporate venturing literature along with theories concerning new service development and customer orientation resulting in the formulation of a distinct conceptual framework. Implications of the findings at a firm level are also discussed to offer future research ideas. Limitations of the research categorised as well.
Figure 1.2  Structure of the research
CHAPTER 2
CORPORATE VENTURING AND CUSTOMER-DRIVEN SERVICE INNOVATION

This chapter reviews literature and theory on service innovation, entrepreneurship, and corporate venturing. Initially, the different views on corporate entrepreneurship and corporate venturing are discussed, analysing the types, definitions, and impact of corporate entrepreneurship and venturing on organisational growth and sustainability. Then, the dynamics of service innovation development are presented, exploring the types, characteristics, factors, and strategies affecting the success of service innovation. In addition, product and service development models, and process are described and examined. The second part of the chapter analyses the role of customers in service development, and investigates the linkages and dynamics of corporate venturing and customer-driven service innovation in healthcare, paying particular attention to the factors and benefits affecting the success of corporate venturing and service innovation in healthcare.

2.1 Corporate venturing and organisational growth

Many studies have pointed out that entrepreneurship focuses on newness, as it is the primary catalyst for innovation, generating wealth creation (e.g. Nambisan and Baron, 2013; Szirmai et al., 2011; Audretsch and Link, 2012). This is achieved by offering new products, developing new processes, or expanding into new markets (Audretsch and Walshok, 2013; Hall et al., 2012).

The pioneer here was Schumpeter (1934), who identified entrepreneurship as the basic activity that creates value for the organisation, consolidating innovation. More recently, Johnson (2001, p. 138), who conducted a study on entrepreneurship and innovation, aiming to clarify the meanings of both terms, stated “entrepreneurship, in its narrowest sense, involves capturing ideas, converting them into products and or services and then building a venture to take the product to the market”. This reinforces Antoncic and Hisrich’s (2003, p. 9) point of view that “…entrepreneurship exists only when new combinations are actually carried
out and ceases when this process is completed.” In contrast, other researchers focus on the organisation and procedures of entrepreneurship. For example, a study by Shane and Venkataraman (2000) indicates that the groundwork for wealth creation through entrepreneurship comes by discovering and utilising profitable opportunities. This is similar to the conclusion of the study by Morsheda (2005, p. 2), which states, “Entrepreneurship is concerned primarily with identifying market opportunities and creating a set of resources through which they can be exploited.” However, Churchill (1992, p. 586) was the first to combine the two viewpoints stating that “…entrepreneurship as the process of uncovering and developing the opportunity to create value through innovation and seizing that opportunity without regard to either resources (human or capital) or the location of the entrepreneur – in a new or existing company”. Furthermore, many researchers note that entrepreneurship represents an individual or organisational behaviour (e.g. Hitt et al., 2011; Lee et al., 2011). Bhardwaj et al. (2011, p. 188), who presented a paper that studies many factors that stimulate entrepreneurial behaviour, mentions, “entrepreneurial actions help to provide competitive advantage for firms facing rapid changes in industry and market structures, customers’ needs, technology and societal values”.

Consequently, it comes to light that entrepreneurship is a creative action that identifies and avails itself of unexploited business opportunities (Mueller and Shepherd, 2014; Bergh et al., 2011). The definitions of entrepreneurship in the literature cover a wide range of practices and actions, including exploration of opportunities (Alvarez et al., 2013), innovation and creation of an organization (Baron and Tang, 2011), and creation of new visions (Timmons, 1990). Leibenstein (1968 p. 73) was one of the first who tried to define entrepreneurship as “...the activities necessary to create or carry on an enterprise where not all the markets are well established or clearly defined and/or in which the relevant parts of the production function are not completely known”. Nasution et al. (2010) carried out a research aiming to examine the effect of entrepreneurship and business orientations on innovation and customer value. In their recent study, they (p. 2) define entrepreneurship as “a process of enhancement of wealth through innovation and exploitation of opportunities, which requires the entrepreneurial characteristics of risk-taking, autonomy, and proactiveness.” It is important to mention, however, that apart from developing better products than competitors, entrepreneurial activities should direct the industry in identifying customers’ advance needs.
(Nasution et al., 2010). This relation between entrepreneurship and customer orientation is not well explored in the marketing literature. This section defines corporate venturing and presents the different types that affect the level and the outcome of innovation. It also describes the characteristics of corporate venturing that affect organisational innovativeness, growth, and sustainability.

2.1.1 Initial views on corporate entrepreneurship and corporate venturing

Many scholars identify corporate entrepreneurship (Figure 2.1) as an organisational capability that promotes entrepreneurial behaviour within organisations to overcome internal barriers, challenge bureaucracy, and encourage innovation through novel business schemes (e.g. Salvato et al., 2009; McFadzean et al., 2005). Other researchers recognised corporate entrepreneurship as an applicable method for organisational survival and corporate competitiveness (e.g. Zellweger and Sieger, 2012; Sebora et al., 2010). According to Covin and Miles (1999), various forms of newness - such as organisational renewal and product or process innovation that reinstate the organisation - produce competitive advantages and lead to business survival.

![Diagram of Corporate Entrepreneurship](image)

*Figure 2.1  Corporate entrepreneurship (Source: McFadzean et al., 2005)*

Similarly, Barringer and Bluedorn (1999), who investigated the relationship between corporate entrepreneurship intensity and strategic management in U.S. manufacturing firms,
argued that corporate entrepreneurship uses the fundamentals of management and applies to exploit opportunities, take risks, and create value to the firm and its customers (Hoskisson et al., 2011). Likewise, Kraus and Rigtering (2010), who see corporate entrepreneurship as a company philosophy, cite it as a strategic mean that improves firm’s innovative capability and raises employee satisfaction. This is in conformance with the definition given by Kemelgor (2002, p. 69) that “corporate entrepreneurship may be viewed as an extension of programmes that embrace employee participation; conscious efforts to instil entrepreneurial practices within corporations are intended to enhance the ability of the firm to: (a) produce or acquire new products or services; and (b) manage the innovation process”. Dess et al. (2003, p. 352), in their review of the literature state that corporate entrepreneurship is “...the driver of new businesses within on-going enterprises as achieved through internal innovation, joint-ventures or acquisitions, strategic renewal, product, process, and administrative innovations, diversification, and processes through which individuals’ ideas are transformed into collective actions through the management of uncertainties”.

However, Levie et al. (2014) and Dunlap-Hinkler et al. (2010) carried out studies that conclude that corporate entrepreneurship can be influential not only for organisations but also for entire economies as it enhances global competitiveness, creates new industries and markets and increases productivity. Various broader or narrower definitions, though, have been discussed in the literature. For example, Rutherford and Holt (2007, p. 430), who investigated the relationship between corporate entrepreneurship and innovation, described corporate entrepreneurship as “...the process of enhancing the ability of the firm to acquire and utilise the innovative skills and abilities of the firm’s members”, while McFadzean et al. (2005, p. 352) agreed that is “...the effort of promoting innovation from an internal organisational perspective, through the assessment of potential new opportunities, alignment of resources, exploitation and commercialisation of said opportunities”. No matter how corporate entrepreneurship is defined, it is a key means of increasing corporate success through the creation of new corporate ventures within or outside the organisation (Kelley, 2011). Considering the interests and focus of this study, the definition of McFadzean et al. (2005) will be adopted, which combines the concepts of corporate entrepreneurship, innovation, and organisational resources, allowing the researcher to demonstrate and discuss the emerging dynamics between these concepts and to synthesise theory, delving into the
details of venturing activities and analysing the opportunities that occur through the active exploitation and exploration of innovation. It is also important to note that no negative implications of corporate entrepreneurship and venturing have been mentioned or analysed in the literature. Zahra, Covin and Miles, Sharma and Chrisman, Kuratko, and other experienced researchers in the field, who have conducted a large number of empirical studies on corporate entrepreneurship and venturing have tested hypotheses and concluded that corporate entrepreneurship and venturing advance companies’ overall performance, profits and growth in revenue. In particular, a recent study by Kuratko et al. (2015), which reviews the past research in the corporate entrepreneurship literature and discusses potential future directions, report that corporate entrepreneurship and venturing advance firms’ capabilities to overcome the innovation challenges that organizations deal with in this new global economic reality.

2.1.1.1 Types of corporate entrepreneurship affecting organisations’ innovativeness

Corporate entrepreneurship can take a number of forms, which are described and analysed below:

- Intrapreneurship is the establishment of new business ventures within the organisation (Halme et al., 2012);
- Dispersed entrepreneurship builds the appropriate structures and develops the culture across the organisation that promote entrepreneurship and innovation and encourage employees to undertake the new business (Belousova and Gailly, 2013) and
- Corporate venturing, which promotes innovation by developing strong relationships with smaller ventures in the target-market (Battistini et al., 2013).

Covin and Miles (1999, p. 50) developed a taxonomy of four types of corporate entrepreneurship (Table 2.1). The aim of organisational rejuvenation is to improve the firm’s ability to implement already successful strategies, changing the firm’s internal processes, structures, and capabilities to retain or achieve a better competitive positioning (Covin and Miles, 1999). They argue that innovation in production/delivery processes; administrative techniques and human resources operations can assist organisations to become more entrepreneurial by creating and transferring knowledge. On the other hand, strategic renewal
indicates the redefinition of the firm’s strategy by changing the way it competes. In addition, strategic renewal is the phenomenon that amends existing strategies to reapportion the firm’s resources and more efficiently utilise product-market opportunities. This is achieved when repositioning activities characterise the exploration and exploitation of novel or existing competitive advantages.

Domain redefinition is the phenomenon whereby the firms follow proactive strategies, developing innovative products and/or entering into markets that others have not recognised or have underserved. The focal points for domain redefinition are bypass strategies and product-market pioneering to develop sustainable competitive advantages. The exploration of new product-market opportunities and proactiveness also lead to early mover advantages, demonstrating a strong entrepreneurial orientation (Javalgi et al., 2014; Kreiser et al., 2013). Finally, sustained regeneration is, perhaps, the most widely recognised phenomenon for firms that choose continuously to develop new products and/or expand into new markets (Covin and Miles, 1999). Those organisations have built flexible structures, entrepreneurial cultures, and swift decision-making capabilities that encourage innovation and market expansion with new or existing offerings to improve their competitive standing. They also support knowledge creation and change to increase their market share and enhance their value.

Table 2.1  Some key attributes of the four forms of corporate entrepreneurship

<table>
<thead>
<tr>
<th>Form of corporate entrepreneurship</th>
<th>Focus of corporate entrepreneurship</th>
<th>Typical basis for competitive advantage</th>
<th>Typical frequently of new entrepreneurial acts*</th>
<th>Magnitude of negative impact if new entrepreneurial act is unsuccessful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational rejuvenation</td>
<td>The organisation</td>
<td>Cost leadership</td>
<td>Moderate frequency</td>
<td>Low-to-Moderate</td>
</tr>
<tr>
<td>Strategic renewal</td>
<td>Business strategy</td>
<td>Varies with specific form manifestation</td>
<td>Less frequent</td>
<td>Moderate-to-High</td>
</tr>
<tr>
<td>Domain redefinition</td>
<td>Creation and exploitation of product-market arenas</td>
<td>Quick response</td>
<td>Infrequent</td>
<td>Varies with specific form manifestation and contextual considerations</td>
</tr>
<tr>
<td>Sustained regeneration</td>
<td>New products or new markets</td>
<td>Differentiation</td>
<td>High frequency</td>
<td>Low</td>
</tr>
</tbody>
</table>

*New entrepreneurial acts for

(Source: Covin and Miles, 1999)
2.1.1.2 Definitions of corporate venturing

As a component of corporate entrepreneurship, corporate venturing has become a core concept in the strategic planning of some organisations as a means of achieving long-term growth and competitive advantages (McKelvie et al., 2014; Korsgaard and Anderson, 2011). Many authors claim that corporate venturing is a strategy for business development, linked to both novelty and corporate renewal, and is accomplished by starting a business within an organisation (e.g. Garrett and Neubaum, 2013; McGrath et al., 2012). Furthermore, corporate venturing concerns investment in high-risk activities, frequently related to those of the parent organisation, which introduce new products or enter into new markets, establishing new companies (Narayanan et al., 2008). Several studies highlight that corporate venturing initiatives may lead to investments with a high growth potential or to constitutional changes in the core business of the parent corporation by expanding its operation into different industries (e.g. Park and Steensma, 2012; Basu et al., 2011). Similarly, many researchers argue that corporate venturing compels strategic change, increases the firm’s profits, and conduces to the consecution of its corporate strategy (e.g. Lin and Lee, 2011; Zahra and Hayton, 2008).

However, ideas for new businesses can be generated either inside or outside the organisation. Firms usually harness both internal and external sources to have access to information, technologies, innovation, business practices, and/or networking with other companies that can enhance growth and profitability (Narayanan et al., 2008). In such case, firms may need new equipment, people, and knowledge (Husted and Vintergaard, 2004). Sharma and Chrisman (1999, p. 19-20) agree with this, stating “…external venturing refers to corporate venturing activities that reside outside the existing organisational domain,” while internal ventures are “…activities that result in the creation of organisational entities that reside within an existing organisational domain.” Likewise, Narayanan et al. (2008, p. 2), who conducted detailed research on corporate venturing, underline that corporate venturing “…is the set of organisational systems, processes and practices that focus on creating businesses in existing or new fields, markets or industries, using internal and external means. Internal means typically include innovation and new business incubation. External means usually include licensing, joint venturing, acquisitions, and corporate venture capital.” In short, a plain but cardinal definition is that of Sharma and Chrisman (1999, p. 19), who define corporate
venturing as “...entrepreneurial efforts that lead to the creation of new business organisations within the corporate organisation”. The definition of Narayanan et al. (2008) will be adopted for this study for the reason that it explains thoroughly the dual dynamics that emerge from both inside and outside the organisation. This detailed definition covers the entire spectrum of the corporate venturing activities that take place in the examined industry, allowing the researcher to present the complex operation of healthcare organisations, and analyse the importance of adopting a collective approach for business growth through the exploitation of corporate venturing opportunities, employing the available internal and external means.

2.1.2 The impact of corporate venturing on organisational growth and sustainability

Firstly, it is worth mentioning the factors that foster corporate entrepreneurship. Hornsby et al. (1993) distinguished those characteristics in organisational and individual. According to this study (p. 30), management support, autonomy and work discretion, rewards and reinforcement, time availability and organisational boundaries are the organisational characteristics that cultivate corporate entrepreneurship. More explicitly, it is important for employees to be encouraged from the management structure to develop new ideas that enhance innovation. This could be achieved by adopting some of these ideas or by supporting pilot projects and providing all the necessary resources to make those ideas profitable. What’s more, organisations should ensure that workers have the exemption to choose the most effective way to perform their work, considering the fudge factor. Firms should also adopt reward policies and reinforcement activities to motivate their employees to adopt innovative behaviour, while at the same time they should be organised in such a way that supplies their employees with the needful time to cooperate with others to develop innovative ideas. Finally, organisations should manage to avoid a highly bureaucratic structure and allow employees to be creative and act faster. On the other hand, some individual factors reinforce corporate entrepreneurship. Such characteristics are the risk-taking propensity, the need for achievement, the internal locus of control, the desire for autonomy, and goal orientation (Hornsby et al., 1993, p. 32).

With regard to corporate venturing characteristics, Narayanan et al. (2008) state that both the intra-organisational factors - such as organisational support, formal controls and numbers of alliances - and environmental conditions - such as technological opportunities,
industry growth and demand for new products - benefit corporate venturing strategy planning and implementation. This study develops a framework, which combines the context, the characteristics, and the outcomes of corporate venturing (Figure 2.2). Lastly, Antoncic and Hisrich (2004) distinguish the critical factors as direct or indirect. For example, the demand for new products has a direct effect on organisational wealth creation and profitability, but influences indirectly the performance of the firm. This study adopts the model of Narayanan et al. (2008), because its takes into account both the internal and external dynamics of the corporate venturing process, such as the forces emerging within the firm’s ecosystem, the organisational context, the firm’s strategies as well as the influencing factors that can either cultivate or hinder entrepreneurial efforts.

![Figure 2.2 CV model for the for-profit sector (Source: Narayanan et al., 2008)](image)

**2.1.3 The impact of corporate venturing on organisational innovation**

Some authors have referred to the dimensions of corporate venturing. For instance, McGrath et al. (2012), and Husted and Vintergaard (2004) argue that although corporate venturing is a risky development process, it should comprise activities new to the firm, like new processes,
technologies and products, to be successful. What is more, the benefits of corporate venturing are synchronously financial and strategic, meaning it enhances the operations of a firm, improves its competitive positioning, and maximises its financial return, which is affiliated to the risk connected to the investment. Moreover, corporate venturing needs ample time to flourish in relation to more traditional business development approaches. On the other hand, other studies by Sharma and Chrisman (2007), and Antoncic and Hisrich (2003), distinguish the dimensions of corporate venturing in:

- New ventures and new businesses, where firms create new autonomous or semi-autonomous businesses;
- Product/service innovativeness, where new products/services are developed or improved;
- Self-renewal, where organisations renew their fundamental values;
- Risk-taking, where innovation or new business creation contains a high risks of failure or losses;
- Proactiveness, where corporations seek new opportunities to develop new product or to expand into new markets.

Likewise, Eriksson et al. (2014), and Gómez-Haro et al. (2011) underlined that proactive organisations are those that pursue leadership through developing new products and introducing new technologies or administrative techniques. Competitive aggressiveness is the final dimension, where the firm chooses to challenge its rivals, to prevail over them (Covin and Lumpkin, 2011). Considering the sensitive nature of healthcare, it is seen that most organisation choose to either create new ventures and new businesses or develop new services of proceed to self-renewal initiatives in order t remain current and competitive. It is not frequently seen by such organisations to make decisions regarding risk-taking developments. It is also not common for healthcare entities to participate in proactive growth initiatives, mainly due to culture, which often prevents change, unless it is necessary or of great importance.
2.1.4 Typologies of corporate venturing and their impact on innovation

Many researchers have tried to identify the types of corporate venturing. For example, Narayanan et al. (2008) found that there are different opinions among existing typologies. MacMillan and George (1985) was one of the first who linked corporate venturing to service innovation. They (p. 34) conceptualised 6 types of corporate venturing based on increasing levels of difficulty:

1. New enhancements to current products and services;
2. New products and services to be sold to current markets within one to two years;
3. Existing products and services that can be sold to new markets within one to two years;
4. New products and services that can be sold to current markets, or existing products and services that can be sold to new markets;
5. New products and services that are unfamiliar to the company but are already being produced and sold by other companies; and
6. New products and services that do not exist today, but could be developed to replace current products and services in known markets or entirely new markets that could be created for the new products and services.

On the other hand, Stopford and Baden-Fuller (1994) presented a typology of the different levels of corporate entrepreneurship, commencing from the individual or corporate entrepreneurship to developing a process of product development and strategic renewal. Yet other researchers have used an internal-external distinction based on either the focus of venturing (e.g. Hill and Birkinshaw, 2012; Lin and Lee, 2011) or whether the entrepreneurial ideas hail from inside or outside the firm (e.g. Narayanan et al., 2008). Similarly, Miles and Covin (2002, p. 26) proposed a four-form typology of corporate venturing (Table 2.2).

<table>
<thead>
<tr>
<th>Table 2.2</th>
<th>A typology of corporate venturing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Presence of investment intermediation</strong></td>
<td></td>
</tr>
<tr>
<td>Direct investment in the venture through the corporation’s operating or strategic budgets</td>
<td>Indirect investment in the venture using financial intermediaries</td>
</tr>
<tr>
<td><strong>Focus of Entrepreneurship</strong></td>
<td>Internal to the organisation</td>
</tr>
<tr>
<td><strong>Entrepreneurship</strong></td>
<td></td>
</tr>
</tbody>
</table>
Direct-internal venturing is the most naïve type of corporate venturing, where the organisation motivates its employees to develop and exploit profitable ideas, providing all the necessary resources for these ideas to flourish. Another type of direct venturing refers to a firm that recognises entrepreneurial opportunities and chooses to exchange knowledge, technology, and/or resources with a smaller venture to acquire all the essential requirements to enter into a market or develop a new product. This form is called direct-external venturing and is beneficial when the business entities develop strong and long-term strategic partnerships. When a collaboration of this kind is successful, the larger organisation obtains several advantages - such as access to new knowledge and to new markets - improving its competitive positioning. At the same time, the smaller organisation borrows resources and capabilities to gain competitive advantages. On the other hand, the reputation of the interested parties and the possibility of cross-purposes may be the most critical risks.

A similar activity to direct-internal venturing is the indirect-internal venturing, where entrepreneurial thinking is also supported within organisation. The difference consists in an independent intermediate, which operates as a venture fund and is managed by corporate employees. This type of venture applies interesting benefits, such as flexibility and objectivity, shorter ramp-up time and safety, comparing with other forms of venturing. On the other hand, the high cost might be a significant disadvantage, as well as the potential for controversy between the already operating companies and the new venture. Finally, indirect-external venturing refers to venture capital funds that are developed by investors, providing strategic and/or financial benefits. Their main aims are the creation or the expansion of existing products and services into new markets, amplifying the operation of the R&D departments. Sharing information and exchanging practices among the fund investors may be another important advantage, even though indirect-external venturing does not comprise capabilities and technology transfers between the established corporations and the new ventures.

It is clear in the aforementioned study that corporations that wish to have integral control over the new venture should choose a direct approach, whereas organisations that seek to build a more independent venture should prefer an indirect investment approach. In
addition, corporations that actively seek corporate venturing as a method to innovate, pursuing culture differentiation and organisational change, should focus on internal venturing, while organisations that pursue quick financial returns should concentrate more on the external mode. However, both internal and/or external focus are appropriate for companies that seek to expand their operations into new markets/industries, exploring business opportunities, or to renew their strategies to sustain or improve their competitive positioning. In addition, Miles and Covin (2002) suggest that organisations that pursue business development and competitive advantages should combine the external and the internal types. What is more, Campbell et al. (2003) have developed four venturing business models based on four different forms of corporate venturing (Table 2.3). Adopting this quadruple approach for corporate venturing, it is common for healthcare organisations to adopt the innovation-venturing model, which combines the strengths and competencies of the partners. For instance, healthcare organisations often pursue partnerships for growth that can combine the three pillars of innovation, sustainability, and customer satisfaction: expertise, resources, and civil acceptance.

**Table 2.3**  
*Key elements of the four corporate venturing business models*

<table>
<thead>
<tr>
<th>Focus</th>
<th>Ecosystem Venturing</th>
<th>Innovation Venturing</th>
<th>Harvest Venturing</th>
<th>Private Equity Venturing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus</strong></td>
<td>Take minority stakes in suppliers, customers and/or complementors to improve prospects of existing businesses. Generate value through commercial links with investee firms</td>
<td>Use venturing techniques as a more effective means of performing (part of) an existing functional activity. Often, but not exclusively, this applies to R&amp;D</td>
<td>Generate cash from harvesting spare resources, and eschew support to existing businesses and &quot;new leg&quot; ideas</td>
<td>Take advantage of a unique deal flow and relevant, non-tradeable assets to participate directly in the venture capital/private-equity industry</td>
</tr>
<tr>
<td><strong>Main Pitfall</strong></td>
<td>The Loss of Focus Pitfall: Investing too widely and seeking too much autonomy</td>
<td>The Culture Change Pitfall: Aiming for a broad impact on culture change rather than focusing on improving part of a function</td>
<td>The New Legs Pitfall: Seeking to develop new growth platforms in addition to harvesting</td>
<td>The Anyone-Can-Do-This Pitfall: Believing that it is easy because others are having success</td>
</tr>
<tr>
<td><strong>Source of Ideas</strong></td>
<td>Mainly external. Venture capitalists and direct approaches from potential ventures. Ideas linked to existing businesses</td>
<td>Mainly internal, but also external venture capitalists and other companies</td>
<td>Mainly internal, but also external venture capitalists and other companies</td>
<td>Mainly external through venture capital network. Ideas screened against pre-agreed search specifications.</td>
</tr>
<tr>
<td><strong>Degree of Autonomy</strong></td>
<td>Separate financial unit reporting to investment board including top management of the existing businesses. Close links to existing businesses through staff overlaps. Each investment should be sponsored by an existing business.</td>
<td>Separate financial unit is not essential: more of a separate process than a unit. Report to investment board led by functional director and advisors external to the function.</td>
<td>Clearly separate financial unit; unit has separate ownership of resources or is an “agent” for primary owner. Reports to top management level, often finance. No special governance required, but a board can be a useful way to involve outsiders.</td>
<td>Clearly separate business and financial unit, located in relevant financial center(s). Report as do other business units. Governance through investment board with a majority of external directors.</td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Required Skills</strong></td>
<td>Requires a small senior-level team of investors, some with strong credibility in the existing businesses and some with strong credibility in the venture capital industry. Team must be comfortable collaborating with existing businesses.</td>
<td>Requires a small team of nurturers, some with strong credibility in the existing businesses and some with good knowledge of the venture capital industry and the process of new business creation. Joint venture skills needed.</td>
<td>Requires a mix of managers: some who understand the resources and some who can sell/do deals. Good knowledge of venture capital industry and process of new business creation. Joint venture skills needed.</td>
<td>Primarily requires venture capital industry specialists with relevant sector experience, some with in-depth knowledge and a network to tap into the host company’s non-tradeable asset.</td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>Operating budgets: investment funds ring-fenced in operating plan but subject to project-by-project sanction.</td>
<td>Operating budgets: budget of replaced activity reduced accordingly; investment funds ring-fenced in operating plan, subject to stage-gate sanction by investment board.</td>
<td>Operating budgets: some limited investment funds; project-by-project funding for significant projects.</td>
<td>Closed-end fund with defined exit date of five years or less: unit funded through annual management fee.</td>
</tr>
<tr>
<td><strong>Performance Measures and Incentives</strong></td>
<td>Significant cash bonus scheme based on impact on existing businesses and portfolio performance; no carried interest.</td>
<td>Performance bench-marked against rest of function: financial interest given to entrepreneurs, not to nurturers.</td>
<td>Cash performance against allocated assets: large bonuses paid against performance targets; no carried interest.</td>
<td>Bonus and share-carry incentives in line with venture-capital industry norms.</td>
</tr>
</tbody>
</table>

(Source: Campbell et al., 2003)

### 2.2 Dynamics of service innovation development

It is widely recognised in the literature that innovation is the key to the growth and economic performance of firms (e.g. Eisingerich et al., 2009; van der Panne et al., 2003). Many studies have concluded that being innovative has become one of the most important factors for organisations in sustaining their competitiveness (e.g. Bernstein and Singh, 2006; Rohrbeck and Gemünden, 2011). Innovation appears to be essential for companies to generate long-term stability, growth, shareholder returns, sustainable performance, maximised employee contentment, and a sustained position at the leading edge of the industry (Salunke et al., 2013; van der Panne et al., 2003). Thus, the concepts of ‘service innovation’, and ‘service innovation strategy’ are explored further below using studies relevant to the healthcare industry, especially the mental health sector. Hipp et al. (2000) argue that firms that innovate are more likely both to increase their sales and to expect to increase their sales in the future.
than are non-innovating firms. Likewise, studies by Maslach (2014), and Fitzsimmons and Fitzsimmons (2008) concluded that firms that fail to innovate will not be threatened in the short-term, but their ability to grow will slow down and therefore, organised continuous innovation efforts are required. For example, the healthcare industry is characterised by constant change, as major innovations have altered the forms in which health services are developed and healthcare is delivered (Bowers, 1987). Hospitals are often leaders in innovation and adaptation to change, as new treatments emerge almost every day and cutting-edge technology forces science to move forward.

It is worth noting the reasons why firms choose to innovate. Tether (2003, p. 497), who carried out a study to explore the degree and the sources of innovation in five service sectors, suggests that firms innovate to replace old services being phased out; to improve service quality; to extend the service range; to open up new markets or increase market share; to fulfil regulations and/or standards; and/or to reduce costs, energy consumption or environmental damage. Nevertheless, a recent study by Rohrbeck and Gemünden (2011), which seeks to discover the potential of corporate foresight in increasing a company’s innovation capacity, mentions that there are enterprises that find it difficult to renew their products, as there is high rate of change, as well as ignorance and business inertia. What is more, there is a high rate of innovation failure, which translates into wasted time, money and human resources as well as poor public image and poor employee morale (Ottenbacher and Harrington, 2010). Considering that corporations operate in a very insecure, highly competitive, and globalised environment, they should always make efforts to differentiate their offerings to obtain corporate survival, wealth creation, and growth. This fierce international competition along with the rapid technological evolution and the advancing expectations of consumers has led to phenomenal changes in service industries (Storey and Hull, 2010). Enterprises, therefore, need to create and sustain competitive advantages and continuously innovate, adopting new processes, creating novel ideas, developing, and launching successful new outcomes. This is supported by many authors including Porter (2004), de Jong and Vermeulen (2003) and Alegre et al. (2013). In addition to the reasons why firms should develop new products, it should be noted that hospitals, for example, must develop new services to extend the time people live or to enhance the quality of living, by curing severe illnesses. This is also underlined by Bowers (1987, p. 35), who stated, “Hospitals
must develop new services and modify present ones to remain current.” Likewise, Duncan and Breslin (2009) conducted a study, which sets out to portray a design programme for converting patients’ needs into health service innovation. They explain why health service providers labour to promote innovation, stating (p. 13) that “increasingly tied to large governmental and private payers, health service providers lack sufficient incentive to provide care in highly innovative ways even if they were to show better outcomes.” Although their research was formed in the U.S., the results are valid for other countries as well. For example, the Greek healthcare system is highly bureaucratic and inefficient in resources management (Bellou, 2010), resulting in a hesitance on the side of entrepreneurs to implement innovative processes and to develop new ventures.

Overall, service development research is seen as an extension of the development process for tangible products (e.g. Rapaccini et al., 2013; Kindström et al., 2013). Likewise, Storey and Hull (2010), who carried out a study aiming to realise how service firms’ competitiveness performs as a strategic contingency affecting both service development and innovation performance; they argued that new service development theory is underdeveloped in both innovation and service management literatures. However, Ottenbacher and Harrington (2010), de Jong and Vermeulen (2003), Anxo and Storrie (2002) noted that services constitute a considerable part of the world’s production, employment, and general economic growth, especially in western economies. This justifies scholars’ interest to explore and analyse the reasons that new service development activities are of vital importance, showing that they strengthen current business and provide new business ventures (e.g. Hidalgo and D’Alvano, 2014; Carlborg et al., 2014). Palo and Tähtinen (2013), and Menor and Roth (2007) also argued that effective new service development is critical to business prosperity and becomes the field of competition for many service organisations. What’s more, service innovation focuses on the design of the service prerequisites that meet customer’s needs and preferences, but some authors still believe that the majority of service enterprises have not adopted modern and formal processes as product companies have done (e.g. Smith et al., 2007; Menor and Roth, 2007). Bowers (1989), for example, argues that those companies who do not restructure and re-strategise will not remain competitive. Still, regardless of the incentives of every firm to develop new services, this is usually attained
either internally through R&D and/or new service development process or externally through licensing or acquisition (Gremyr et al., 2014; Melton and Hartline, 2013).

2.2.1 Definitions of service innovation and development

Many studies have attempted to define innovation. Håkansson and Waluszewski (2014), and Nakata and Benedetto (2012) describe innovation as a form of knowledge and a new way of delivering quality or better value, while Cumming’s analysis (1998) characterises innovation as the creation and first successful application of a new product or process. However, the studies by Leiponen and Helfat (2010), and Galanakis (2006) provide integrated definitions. They outline innovation as the conversion of knowledge and ideas in a new product, service, or process by applying effective scientific or technological knowledge. The outcome has commercial or social value, providing a degree of novelty to the developer, the industrial sector, or the world, and is key to competitiveness. As regards service innovation, few studies have managed to provide a concrete meaning (e.g. Dörner et al., 2011; Agarwal and Selen, 2009). Generally, the term service innovation has been used in the literature to describe both new or improved services as well as the process that generates new service products using new knowledge, processes, and technologies (Bettencourt, 2013).

Den Hertog et al. (2010) carried out research aiming to pinpoint a set of dynamic capabilities for managing service innovation and developed a model that deals with the possible aspects of the situation where service innovation takes place. They argue that a new service experience is a new system of service and/or process that generates value for the consumer. In addition, the degree of novelty depends on customer-producer interaction. Likewise, Berry et al. (2006, p. 56), who conducted a study on market-creating service innovation and also developed a service innovation matrix (Figure 2.3) by adapting Ansoff’s growth-strategy matrix, define market-creating service innovation as “an idea for a performance enhancement that customers perceive as offering new benefit of sufficient appeal that it dramatically influences their behavior, as well as the behavior of competing companies”. Putting all these together, Den Hertog et al. (2010, p. 494) define service innovation as “a new service experience or service solution that consists of one or several of the following dimensions: new service concept, new customer interaction, new value system/business partners, new revenue model, new organizational or technological service
delivery system”. Likewise, Agarwal and Selen (2009) developed a definition focused on innovation’s outcome. They refer (p. 456) to service innovation as a “process, product, and/or organizational innovation and/or even performance and productivity improvements culminating from proactive creation, development, and maintenance of relationships with partners - customers, suppliers, or other stakeholders - resulting in a multidimensional service innovation capability.” The above definition of Berry et al. (2006) for service innovation will be adopted by this study, considering its nature that focuses on customer-driven service innovation. This definition describes the influence of customers, not only on service innovation, but also on the course of competition between the service companies; a phenomenon that is particularly intense in the healthcare industry today. This definition will enable the researcher to synthesise the different aspects of service innovation and customer involvement in service development process, and to discuss the interactions between the innovative organisation and its current and potential customers. The latter is of great value in the healthcare industry, considering the participation of patients and their families in service development, testing, and delivery.

![Service Innovation Matrix](Source: Berry et al., 2006, p. 56)
Considering both the service concept and the classification of the service offering, Preissl (2000) initially defined a new service as the addition of a new service idea or a modification of an existing service in the service concept, allowing a new service offering to be developed. Similarly, Menor and Roth (2008) define a new service as an offering that the company has not developed before, resulting from changes that took place in the delivery process or from an addition to the existing development process. Additionally, some of the new product development definitions could be interpreted (e.g. Marion and Meyer, 2011; Marion and Simpson, 2009). An accurate one that combines both product and service development is given by Loch and Kavadias (2008). They built on several other definitions and concluded (p. 3) that “new product development (NPD) consists of the activities of the firm that lead to a stream of new or changed product market offerings over time. This includes the generation of opportunities, their selection and transformation into artefacts (manufactured products) and activities (services) offered to customers and the institutionalization of improvements in the NPD activities themselves.” Nonetheless, new service development generally refers to the overall process of developing new service outcomes (Lovelock, 2011).

Many studies categorise service innovation as disruptive/radical or sustaining/incremental (e.g. Feller et al., 2011; Varadarajan, 2009). Disruptive or radical innovation refers to innovation that produces revolutionary change in firms, markets and industries, which provide substantially higher customer benefits relative to current products in the industry. In contrast, sustaining or incremental innovation refers to line changes or improvements in a firm’s existing product offerings that satisfy better the needs of its current and potential customers. With regard to health service innovation, it becomes apparent that little research has been conducted on the topic. A recent study by Thakur et al. (2012), which looks into innovation in healthcare, argues that innovation helps medical professionals provide high quality care in a faster, better and cost effective method. It also describes healthcare innovation (p. 564) as “adoption of those best-demonstrated practices that have been proven to be successful and implementation of those practices while ensuring the safety and best outcomes for patients and whose adoption might also affect the performance of the organization.” Lin, Ramakrishnan et al. (2013), who carried out a study combining the concepts of service design, healthcare compliance, and gamification to develop a web-based behaviour motivation tool to improve patients’ health compliance, described the innovation
of motivation-embedded services using a service innovation matrix for behaviour-motivation-embedded services (Figure 2.4). They argue that since older service systems have evolved due to the evolution of information and communication technology, service innovations now begin from technology, involving social-organizational novelty, and contributing to business innovations. Within this process of service innovation; engineering, design and management issues need to be addressed (left diagram in Figure 2.4). Then again, the three phases of feasibility studies also need to be considered, because the aim of this matrix is to guide service innovation (right diagram in Figure 2.4).

![Service Innovation Matrix for Behavior-Motivation-Embedded Services](source: Lin, Ramakrishnan et al., 2013, p. 65)

### 2.2.2 Typologies of new services

Many scholars classify service development as either radical or incremental (e.g. Colombo et al., 2014; Crawford and Di Benedetto, 2002). First, Booz et al. (1982) reported six different types of product development: products new to the world, that are innovative for both producer and customers; new product lines that are new to the developer but not necessarily to the customers; additions to existing product lines, which are new products that supplement existing product lines; improvements and revisions to existing products, which refer to improved products with better performance that replace current products; repositioning, which pertains to existing offerings that are promoted in new markets; and cost reductions, which are new or improved products that have similar performance to the existing offerings, but cost less in development and supply.
Likewise, Lovelock (1984) has categorised products as: major innovations, which are new offerings for both provider and users; start-up businesses, which refer to new products or new ventures for a market that is already being served; new products for the currently served markets, which are new offerings for existing customers; product line extensions that increase the offerings in a current product line; product improvements, which refer to improved products currently on offer that replace existing offerings; and style changes that involve alterations to current products. More recently, Crawford and Di Benedetto (2002) categorised new products into five classifications: new-to-the-world products, which have never been offered before; products or categories new to the firm; line extensions or additions to existing product lines; improvements of current offerings; and existing products that are offered in new markets.

Based on those taxonomies, other researchers have also classified service innovativeness (e.g. Wallace, 2007; Menor et al., 2002; De Groot et al., 2002). For example, Goedhuys and Veugelers (2012), and Eggert et al. (2011) recognise three kinds of product innovations: breakthrough projects, which refer to constitutive modifications to current services and processes; platform projects, which pertain to new service lines; and derivative projects, which refer to minor changes to services and processes. Avlonitis et al. (2001) carried out comprehensive research on new financial services that revealed six types of service innovativeness, namely, new to the market services; new to the company services; new delivery processes; service modifications; service line extensions; and service repositioning (Table 2.4). They have found that each type is associated with different development policies as regards formality, activities, and cross-functional involvement and performance outcomes. It also emerged that the two ends of the innovativeness continuum seem to be very successful in non-financial terms, compared to the less innovative outcomes that display thriving financial performance.

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<tr>
<td>New to the world products</td>
<td>Step-out product development</td>
<td>Major innovations</td>
<td>Highly innovative products</td>
<td>Innovations in service products</td>
<td>Breakthrough projects</td>
<td>New to the market services</td>
<td>New to the world products</td>
</tr>
</tbody>
</table>

Table 2.4 Summary of classifications of new product/service innovativeness
Similar to those positions, Ansoff (1987) developed a matrix based on market newness and product newness, illustrating the dimensions of product/service development (Figure 2.5).

There are a number of different levels of innovation in healthcare. For instance, collaborative actions that improve the delivery of existing services are considered as incremental innovations. One example derives from multidisciplinary health teams - including nurses, clinic clerks, diagnostic services staff, doctors, secretaries, and managers -, who work together both within and across organisations with a commitment to improving services. This approach reduces the waiting times, streamlining the provided services at the outpatient departments. Another example of service innovation comes from the Luton and Dunstable hospital in the UK. There, the patients and the carers share their stories about the treatment and overall experience in the hospital. These insights are taken by the service designers and the health teams and are used in an effort to designing and develop experiences rather than services, systems or processes. This novel approach can lead to significant radical innovation outcomes
through the identification of areas that need improvement or redesign (27). Such an example was the RED project in the Bolton area of north west England, in which a number of residents suffer from diabetes, almost one individual in every ten households. This number of incidents absorbs 5% of NHS resources locally, and 10% of hospital patient resources. The medical model of the local NHS had some limitations regarding the interface between patients, professionals, and workers in the diabetic centre. The RED project was an initiative that focused on the ways by which the interface between people with diabetes and a range of required services could be improved and on how diabetics could support each other. The first stage of the project examined the individual lives of a group of volunteers who were diabetes sufferers ready to share their experiences of living with the condition. Scientists aimed at understanding the real issues that affect sufferers’ ability to manage their diabetes effectively day to day. Some common patterns emerged within the group of volunteers, which enabled the researchers to identify three profile categories based on how individuals approach and manage their condition: ‘knowing struggler’, ‘determinedly naïve’, and ‘able knower’. Those findings allowed scientists to redesign the service, advancing extensive prototyping and experimentation.

Similarly, the Lambeth Living Well Collaborative is an initiative in the UK, including a group of service users, GPs, providers and commissioners dedicated to transforming Lambeth’s mental healthcare system, promoting co-production of the provided service on a large scale aiming at improving the outcomes for people with mental health problems, regardless of the severity of their condition. The initiators and coordinators of this project believe on the idea that people’s needs are better met when they are involved in an equal and reciprocal relationship with professionals. A series of workshops take place to generate insights from both professionals and service users to create a framework that will help the professionals to integrate the co-production approach into their everyday operations. The goal of this initiative is to build sufficient capacity and a positive culture in primary care to prevent the move of patients to secondary care. Upon successful development and testing, the co-production in mental health model will be applied on a larger scale to make Lambeth’s mental healthcare system genuinely and entirely co-productive, transforming the quality of life for a number of Lambeth’s inhabitants as well as reducing the burden on its healthcare services. This initiative follows the idea of Bessant and Maher (2009), who propose a new
toolkit for radical innovation in healthcare, integrating the design methods and tools in service innovation. They underline the value of customer involvement in the design and development process of service innovation, which allows the organisations to provide experience innovation as well as customised and tailored service via the forms of co-creation. On the other hand, there are numerous examples of incremental innovations in mental healthcare, including the adaptation of medicines to better meet patients’ needs. In general terms, incremental innovation is marked by developments in therapeutic quality, safety, and efficacy over existing medicines. Such improvements expand the number of treatment and dosing options available, allowing healthcare providers to better treat diverse patient groups.

2.2.3 Characteristics of services affecting innovation

Services have some particularities that affect their development, delivery, evaluation, and competitiveness. According to Jaw et al. (2010), who carried out research on how service characteristics, market orientation, and efforts in innovation together influence new service development performance, argued that service characteristics define the route of an innovation effort. Many studies categorise service products as intangible, inseparable, heterogeneous, and perishable (e.g. Black et al., 2014; Villar et al., 2012; Alam, 2006).

Intangibility refers to the fact that service products are processes and performances rather than physical objects (Moeller, 2010). It is easy for a firm to develop and modify services, compared to physical goods (Pla-Barber and Ghauri, 2012). New service development is mainly based on customers’ needs and preferences and thus, is an informal and ongoing process (Papastathopoulou and Hultink, 2012). It is often unlikely that people use their senses to understand or evaluate a service as they do with tangible products (Cowell, 1988). Although there may be some tangible aspects of services, especially in technological innovations (Ozdemir, 2007), in mental health services is difficult to have a more “tangible” result. However, the literature stands more on the negative aspects of intangibility. It is difficult to test services, but they are easy to imitate. Many researchers note that services can proliferate and this leads to high levels of imitation, as copyright is difficult to obtain (e.g. Lee et al., 2011; Cheng and Krumwiede, 2012). This is probably the reason of why many service firms choose not to make big investments in R&D or customer orientation (Johne and Storey,
1998), but instead make minor changes to existing offerings, trying more to sustain their positioning than to improve it (Norman and Verganti, 2014; Ozdemir, 2007).

Inseparability is another characteristic of services. The production and consumption of intangible products are simultaneous, as provider and user are parts of the experience (Jaw et al., 2010; Alam, 2006). As production and delivery in services is quite the same process, operational staff is able to see whether the customer is satisfied. This emerges from Melton and Hartline’s (2010) findings arguments that staff performs a double role, operational and marketing. Customers’ feedback and suggestions provide an important source for quality improvements and further developments. Heterogeneity is also related to the new service development process, as service experience seems to be unique every time. Many factors influence the special characteristics of services. For instance, service experience varies across service providers and since users are actively involved in the process, the place and time of the transaction play a critical role (Moeller, 2010). Furthermore, the co-production element usually affects the quality of service outcomes, as the requirements and the preferences of the customers are rarely the same (Aurich et al., 2010). In addition, service users are unable to assess a service offering prior to purchase, because it is difficult for businesses to standardise a service (Johne and Storey, 1998). However, Ozdemir (2007) reveals in her doctoral thesis that technological services seem to be less heterogeneous than others, as technology increases the level of standardisation from the producer side. This enhances the notion that highly customised services, such as mental healthcare services, are almost impossible to standardise.

Perishability is the last characteristic of services. According to Striffler (2013), and Cowell (1988), services are disposable offerings that cannot be saved, stored, or returned. Thus, lack of ownership is a basic element and a difference between intangible and tangible products. Customers usually pay for the use of or access to facilities, therefore, service organisations have to make decisions and plans to cope with fluctuating demands (Blut et al., 2014).
2.2.4 Critical factors affecting the success of service innovation

Considering that new service development is a risky process, both practitioners and researchers have made efforts to identify those factors that increase the possibility of success (e.g. Kindström et al., 2013; Lightfoot and Gebauer, 2011). Ottenbacher and Harrington (2010), who conducted a research aiming to investigate the attitude of managers in the development of innovative and incremental new services, report that not much investigation has been undertaken to identify how new services are successfully developed. This leads to lack of coherence in knowledge and research. The question though, is why service innovation is reputed to be a hazardous process. De Brentani (1993) was the first to identify the factors that often generate problems in new service development. She claimed that intangibility and variability often hinder the conceptualisation of a new service offering. The combination of high competition and easy imitation discourage many firms from investment in highly innovative projects. Similarly, new service opportunities through new technologies are often difficult to exploit, as they require complex and costly procedures. Another factor could be the limitations of customer participation. At times, service firms are driven by customers to develop imitative outcomes, as customers are unable to describe future needs or imagine something radically new.

Overall, the product innovation literature has found that a common set of factors, such as those of environment, organisation, strategy and process, affect the performance of a new offering (e.g. Durmuşoğlu and Barczak, 2011; Adner and Kapoor, 2010; Menor and Roth, 2008). This has led a few authors to develop theories that propose the employment of a ‘champion’. Booz et al. (1982), and more recently, Cooper (2001) declared that this role is a critical element for success. The champion is a person who leads and drives the development process. This person is also responsible for managing the insecurity of the top management team and prevailing on them to approve the project. In addition, the team that undertakes the development of a new product influences the performance of the new outcome more than the competitive situation or the nature of the project (Sivasubramaniam et al., 2012). Likewise, a study by Martin and Horne (1993) found that successful firms use champions significantly more often than unsuccessful ones and allow them to manage the new offering in the launch stage. It also concludes that successful service enterprises establish a direction for the types of new products when they seek to develop service line extensions. Kandemir et
al. (2006) adds that the success of the new product development is significantly associated with the resources committed to people (strong champion involvement, use of a multidisciplinary team and the focus of a dedicated team), development (detailed market research), testing (market testing and production start-up), launch (advertising and promotion activities), and international market involvement (international market diversification). Other researchers present a range of factors that strongly influence new product success. For example, Cooper (1994b) proposes four success factors:

1. A differentiated new product that delivers superior value to the customer and a customer-oriented new product process; these separate winners from losers;
2. Pre-development activities, such as idea screening, market research and business analysis, with a sharp product definition, also lead to success;
3. The establishment of a cross-functional team with the implementation of a multi-stage game plan increases the success rate while it also speeds products to market;
4. The focus and determination on decision-making together with quality of execution are required in the new product development process.

Likewise, Lester (1998) has identified three key fields that benefit the performance of the new product development process.

1. Senior management commitment with a supportive culture within organisation constitute essential elements for success;
2. Organisational structure and processes and innovative product concepts enhance the possibility of success;
3. A new product development team with the appropriate knowledge, resources, and project management that focuses on reducing risks are key prerequisites for success.

Based on those studies, some researchers focused on the factors that benefit service innovation. For example, Smith et al. (2007) identified seven criteria that lead to successful innovation in healthcare firms. They argue that the design of a new service outcome should focus on customers’ needs and preferences and be consistent with the objectives, values, and strategies of the organisation. In addition, service companies should be flexible and responsive to changes either in customers’ needs or in external environment (political, social,
etc.). The first three criteria concern service design, while the following four deal with the new service development process. As in service design, customer participation is also crucial to new service development. A structured and well-organised new service development process is essential, with the use of cross-functional teams and stakeholder groups. Finally, effective leadership of the development process is pivotal to success as the senior management team applies its skills and competencies (political, influence and project management) to overcome any difficulties and meet the financial targets. Additionally, Edgett and Parkinson (1994) and Laeven et al. (2014) have identified the determinants of success in new financial services. Services developed by strong cross-functional team cooperation, market synergy and effective market research seem to have a high probability of success. In addition, effective launch strategies using strong communication materials, market potential, and extensive design testing have been found to influence the performance of a new service offering. Formal development processes and detailed business analysis also benefit a new service offering.

Recently, Jin et al. (2010) attempted to identify the key new service development factors that determine the success of a new offering. They found that new service success is connected with practices in the related administrative methods, and thus they sort the success factors into four management processes, i.e. NSD strategy management; customer involvement; NSD knowledge management; and NSD process management. They made an in-depth review of the literature and assembled the major success factors from several studies in a table (Table 2.5).
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<thead>
<tr>
<th>Reference</th>
<th>NSD Strategy Management</th>
<th>NSD Process Management</th>
<th>NSD Knowledge Management</th>
<th>Customer Involvement</th>
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<tbody>
<tr>
<td>de Brentani (1989)</td>
<td>Corporate synergy</td>
<td>NSD process</td>
<td>Expert service</td>
<td>Market need</td>
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<td>Market orientation</td>
<td>Service quality</td>
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<td>Market synergy</td>
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<td>Service modifications</td>
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<tr>
<td>Cooper and de Brentani (1991)</td>
<td>Market size &amp; growth</td>
<td>Quality of execution of launch activities</td>
<td>Service expertise</td>
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<td>Product market fit</td>
<td>Quality of execution of marketing activities</td>
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<td>Product uniqueness &amp; superiority</td>
<td>Quality of execution of pre-development activities</td>
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<td>Synergy with regard to expertise and resources</td>
<td>Quality of execution of technical activities</td>
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<td>Tangible evidence</td>
<td>Quality of service delivery</td>
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<td>de Brentani (1991)</td>
<td>Market attractiveness</td>
<td>Detailed/formal NSD process</td>
<td>Expert-/people-based service</td>
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<td>Overall corporate synergy</td>
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<td>Utilization of expertise in the firm</td>
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<td>Service newness to firm</td>
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<td>de Brentani and Cooper (1992)</td>
<td>Product advantage</td>
<td>Quality of execution of launch activities</td>
<td>Service expertise</td>
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<td>Customer service</td>
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<td>Product/company fit</td>
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<td>Product/market fit</td>
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<td>Cooper et al. (1994)</td>
<td>Product advantage</td>
<td>Market-driven NSD process</td>
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<td>Customer service</td>
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<td>Market-driven NSD process</td>
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<td>Edget (1994)</td>
<td>Business/financial analysis</td>
<td>Formalization</td>
<td>Organizational (e.g., high qualified members and inter-functional cooperation)</td>
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<td>Market potential</td>
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<td>Market synergy</td>
<td>Project update</td>
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<td>Resource allocation</td>
<td>Thorough testing</td>
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<td>Well planned launch</td>
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<tr>
<td>de Brentani (1995)</td>
<td>Synergistic with firm’s established reputation and resource</td>
<td>Involve some type of ‘NSD Proficiency’ through a formal process</td>
<td>Respond to market needs</td>
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<tr>
<td>de Brentani and Ragan (1996)</td>
<td>Client and marketing fit</td>
<td></td>
<td>Service expertise</td>
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<td></td>
<td>Market size/potential</td>
<td></td>
<td>Customer participation</td>
<td></td>
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<td></td>
<td>Service newness to firm</td>
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<td></td>
<td>Service superiority/innovativeness</td>
<td></td>
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<tr>
<td>Oldenboom and Abratt (2000)</td>
<td>Degree of service newness</td>
<td>Detailed prediction studies</td>
<td>Adequate skills and resources</td>
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<td></td>
<td>Product advantage</td>
<td>Precision</td>
<td>Cross-functional integration</td>
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<tr>
<td></td>
<td></td>
<td>Formatted plans</td>
<td>Consumer insights</td>
<td></td>
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<tr>
<td>Avlonitis et al. (2001)</td>
<td></td>
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<tr>
<td>de Brentani (2001)</td>
<td>Market potential</td>
<td>NSP process formality</td>
<td>Cross-functional involvement</td>
<td></td>
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<tr>
<td></td>
<td>Service complexity/cost</td>
<td></td>
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<tr>
<td></td>
<td>Service quality evidence</td>
<td></td>
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<tr>
<td></td>
<td>Strategy and resource fit</td>
<td></td>
<td></td>
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<tr>
<td>Ottenbacher et al. (2006)</td>
<td>Market attractiveness</td>
<td>NSP process formality</td>
<td>Cross-functional involvement</td>
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<td></td>
<td>Market synergy</td>
<td></td>
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<td></td>
<td>Strategic human resource management</td>
<td></td>
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</tr>
<tr>
<td>Oke (2007)</td>
<td>Innovation strategy</td>
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Note: Only significant NSD success factors are listed.
It has been clear in the product and service innovation literature that the factors that benefit the development of a new outcome are quite concrete (e.g. Nieto and González-Álvarez, 2014; Ceschin, 2013). For example, Edgett (1994) investigated new service development activities in British financial institutions and concluded that successful firms have managed to develop organisational activities in parallel with appropriate resource allocation. He found that both formalisation of the development process and up-front activities appeared to have significant value in new service success. In addition, customer orientation, via market research and market potential, and harmonisation with the company’s values, image, and strategies are critical to success (Gustafsson et al., 2012). In other words, the appeal of the market place and the organisation’s aptitude to launch new offerings that respond to market needs lead to financial success (Cheng and Krumwiede, 2012).

On the other hand, when it comes to services, Ottenbacher and Harrington (2010) argue that it is the perceived quality of the interaction with the customers - such as the expertise and enthusiasm of frontline staff, rather than the service product itself - that should be considered the key success factor. All the same, financial analysis and project updates contribute to the success of the development project. Finally, launch effectiveness is closely related to the success of the new service offering. A well-planned promotion process using effective marketing tools, supported with adequate resources, is demonstrably beneficial to the development of new services. In addition, Smith et al. (2007), who implemented five different models on the design and development of new healthcare services, found that in order for a development process for health services to be successful, service design should be harmonised with, on one hand the organisation’s objectives and strategies, and on the other with the interests and expectations of the key stakeholders (government, health board, etc.) Moreover, they mentioned that service design should focus on users’ needs and involve customers in the development process, utilising a range of other stakeholders, such as frontline staff, managers and so on. Finally, it is emphasised that the development process must be well structured, flexible, and fast.

2.2.5 Strategies affecting the success of service innovation

It is clear in the literature that innovation is a risky option (e.g. Bowers and Khorakian, 2014; Duarte, 2010) and therefore, firms should plan strategically for the implementation of service
innovation. Studies have shown that innovation strategy provides a clear direction for dealing with strategic issues, such as selecting the markets to enter and the skills to develop (e.g. Johnston and Bate, 2013; Yalabik et al., 2012). Innovation also focuses the effort of the entire organisation on a common goal (Igartua et al., 2010). Furthermore, a study by van der Panne et al. (2003) underlines the importance of strategy, stating (p. 314), “strategically planned projects enable the firm to take advantage of synergy between parallel innovation projects.” Oke et al. (2012) add to this, mentioning that a top management team needs to develop the strategy and communicate the role of innovation within the company, to decide how to use technology and to drive performance improvements using appropriate innovation indicators. They also suggest that the first step in developing an innovation strategy is to define what innovation means to the firm. Several studies address innovation strategy as a success factor. For example, reports by Teece (2010), and Lendel and Varmus (2011) maintain that innovative activities should be given a strategic direction to maximise the benefits of previous innovations. Similarly, other authors argue that firms that are more successful have a greater commitment to innovation (e.g. Tushman and O'Reilly, 2013; Salunke et al., 2011). This evidence points out that most firms have some form of innovation strategy, with successful firms being more committed to such planning.

A Mercer Management Consulting (1994) study suggested that high performing companies had visible signs of commitment to product innovation, especially in terms of providing adequate funding and resources, and communicated their strategy to all the stakeholders. Likewise, Oke (2007) observed that highly innovative service firms have an explicit service innovation strategy that guides the development of new services. Di Benedetto (2012) also recognised that innovations should be based on a new product plan or a product innovation charter, which according to Crawford (2006, p. 59) is “the strategy statement which flows from a situation analysis.” He also highlights that the product innovation charter is constituted by three elements: strategic arena, goals of the new product activity, and programme to achieve these goals.

Categorization of innovation strategies

The previous sections interpret the numerous innovation strategies defined in the literature. Another common typology, though, distinguishes proactive from reactive strategies.
Kandemir and Acur (2012) note that proactive innovation strategies pursue product innovations to obtain product leadership. Naranjo-Valencia et al. (2011) add that proactive strategies favour the development and introduction of early and breakthrough innovations. They also note that the management of such innovations should have a tolerance for failure, along with a strong focus on the key innovation that will change the entire competitive structure of an industry. On the other hand, innovations that are incremental and relatively late are called reactive (Talke et al., 2011). Reactive innovation strategies pursue product development as a protection against competing products (Yang and Li, 2011) and place more emphasis on process innovation rather than product innovation (Gebauer et al., 2012). This proposes that such innovators adopt other’s innovations, as there is a need for them to stay current, so they spend more time and attention on their competitors than do proactive innovators. Nevertheless, Fan et al. (2012) point out that most companies choose to pursue an innovation strategy that mixes the pure proactive and the pure reactive. They bring out three factors for the selection of an innovation strategy. The first one is the industry in which the firm operates.

Several studies have shown that this is an important factor in the formation of an innovation strategy (e.g. Nybakk et al., 2011; Cassiman and Veugelers, 2006). The second factor is the history and the overall strategy of the firm. Each company pursues a particular innovation strategy according to its business strategy and its support systems (Ritter and Gemünden, 2004). The last factor is the human and the material resources that the firm possesses. A study by Ulrich (2013) argues that creative people and an R&D operation are needed for a proactive innovation strategy to be successful. It has been clear that in this fierce and fluid economic environment, companies should constantly create novel ideas and develop new offerings to sustain and improve their competitive positioning. One of the first studies that dealt with product development was Booz et al.’s (1982), who reported that new product strategy is a link between the organisation’s objectives and goals and new product outcomes. They also suggested that strategies determine both development and screening criteria for new products. Many scholars emphasise new product strategy as it relates to the overall business strategy for development success (e.g. Wei et al., 2014; Teece, 2010). In other words, a product plan should accord well with the organisation’s strategic goals, image, and vision.
(Johnston and Bate, 2013) and therefore, new product development strategy is a prerequisite for successful product innovation (de Brentani et al., 2010)

Product strategy and planning determines the decisions about designing and delivering products, targeting markets, adopting technologies and allocating resources (Johnston and Bate, 2013; Mills, 2012). Additionally, effective new product development strategies secure that the new outcome meets customers’ expectations and demands (Yarbrough et al., 2011). Nevertheless, Storey and Kelly (2001), and Ahmed et al. (2014) noticed that many firms speed up the development process without first forming and implementing a strategy. This often leads to unsuccessful attempts of innovation. Many scholars have focused their research on the strategies that service firms should develop and follow. For instance, Edvardsson et al. (2013) argue that new service strategy determines the innovativeness of a new service offering, while Storey and Kelly (2001) report that the firms that constantly develop successful new services feel inclined to have a clearer development strategy than their less successful counterparts. They also note that these strategies should be formal and aim at long-term success. In addition, Jin et al. (2010, p. 2010) state, “an NSD strategy defines the roles of NSD within the overall business strategy and drives and directs the NSD efforts.” Yet, they mention that best-performing companies consume considerable resources than less successful challengers and quote survey outcomes, which confirm that successful firms are expected to build up strategies for the development of new offerings.

Scheuning and Johnson (1989) developed a matrix that illustrates four service strategies (Figure 2.6). First is the share building strategy, which aims to sell more offerings that are current to existing customers, often by aggressive promotions. Second is the line extension strategy, where companies seek to promote new services to current buyers. Third is the market extension strategy, where firms plan to promote existing services to new market segments either nationally or internationally. Last is the new business strategy, where enterprises create new business ventures and develop new offerings to expand into new markets and seize on unexploited opportunities. This last strategy is often adopted by healthcare organisations that aim to advance their offerings while covering a wider range of potential customers.
Likewise, a study by Nadeau and Casselman (2008) about new product development strategies and their implications on product life cycle, reports eight common strategies used to develop new products (Table 2.6).

1. The pioneer strategy refers to the development and launching of highly innovative products where no similar offerings exist to satisfy a market need. Firms adopt this strategy to be leaders in a market and meet first customers’ needs, using, at the same time, techniques to protect their efforts, such as legal barriers, better features than competitors, vigorous promotions, registered patents and so on.

2. Imitation is viewed as an effective and less risky product development strategy than pioneer strategy. The success of this strategy is based on the rapid imitation of the new product, avoiding the risks taken by the first mover. The follower can also make substantial improvements or cost reductions and hence offer a product that meets customers’ expectations better.

3. Rapid innovation strategy aims to simplify and accelerate the procedures of new product development. Making little modifications to products frequently results in continuous new offerings to the market place, creating competitive advantages for the organisation. Moreover, rapid innovation strategy often extends the life cycle of a product, as additional utility is brought about through supplementary features.

4. Disruptive technology strategies contribute to the development of radical products that usually supersede existing offerings, providing a different set of attributes. Disruptive technologies are often used as a tool for the first mover to gain competitive advantages in the creation of and expansion into new markets.
5. Companies may also choose to communicate publicly their intention of launching a new product. The strategic impetus for firms to implement preannouncement strategies is the perceptual barriers to entry; the standard setting; customer-switching costs; fund raising; strategic communication; and the game of competition. For example, preannouncements may have an adverse influence on the development plans of competitors or discourage customers from making purchases until the new product is launched.

6. Many firms choose to cooperate with others to develop new products. This is happening between firms as they exchange technologies, capabilities, and knowledge about a new offering or a market place. Partnering strategies also help companies to spread the development costs and moderate the risks of their investments. On the other hand, it seems likely that products that are developed by more than one firm may not be highly innovative. Thus, smaller firms should pursue such collaborations and implement partnering strategies, as they probably lack resources or do not have the competences and access to technology to go it alone.

7. Standard-setting strategies refer to situations where users determine the value of the product. When the standards of a product change, there is high competition between the companies involved, and every party makes efforts to adopt such strategies to prompt the market or the formal standard organisation bodies to their benefit.

8. Product platform strategies mainly concern technology firms. On one hand, platform strategies help firms to become leaders in a system where companies develop independently innovative products of technology, such as Intel’s microprocessors. On the other hand, platform strategies provide firms with the ability to develop proprietary technology that is used as a base upon which future products are built.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Introduction</th>
<th>Growth</th>
<th>Maturity</th>
<th>Decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pioneer</td>
<td>First mover advantage</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Imitator</td>
<td>Strong benefit</td>
<td>Decreasing</td>
<td>Only useful if cost advantages</td>
<td>Only useful if cost advantages</td>
</tr>
<tr>
<td></td>
<td></td>
<td>benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid innovation</td>
<td>First mover advantage</td>
<td>Steal competitors’ growth</td>
<td>Extend life cycle</td>
<td>Limited benefit</td>
</tr>
</tbody>
</table>

Table 2.6 New product development strategies and the product life cycle
Disruptive technologies | Create new market - First mover advantages | Strong benefit | Terminate incumbents | N/A
---|---|---|---|---
Preannouncement | Financing strategy, perceptual barriers | Standard setting, switching costs | Strategic communication, competitive games | Strategic communication, competitive games
Partnering | Strong benefit - absorptive capacity | Strong benefit - growth and learning | Limited benefit - cost only | Limited benefit - cost only
Standard setting | Cooperate until technology is legitimate | Standard set, market segmentation and cost | Competitive phase - erect entry barriers | Competitive phase
Use of platforms | Limited applicability | Strong aid to growth | Critical component of survival | Weakens but some lasting benefits

(Source: Nadeau and Casselman, 2008)

2.2.6 Models of product and service innovation

Studies have explored the adoption of a systematic process in new product and service development and discovered its key role in reducing the risks of failure (e.g. Durmuşoğlu et al., 2013; Bendoly et al., 2012; Kim and Meiren, 2010). New product and service development processes involve a series of steps or phases between the moment an idea is generated and its commercialisation in the market place. Both new product and service development strategy and process are found to play a critical role in the performance of the new offering (Edvardsson et al., 2013). Companies usually adopt formal development processes that lead to new product success and such processes generally consist of stages, pre-specified activities, and evaluation points (Papastathopoulou and Hultink, 2012). There are many product innovation models in the strategic marketing literature that aim to portray the development process (e.g. Peres et al., 2010; Salunke et al., 2011). Given that a limited number of new service development models have been developed, this section reviews some major new product development models to delineate a richer perspective. In the new product and service development models, six groups may be distinguished (Kim and Meiren, 2010; Dolfsma, 2004):

1. Activity stage models focus on the tasks that need to be done at each stage;
2. Decision stage models focus on the evaluation points and on the decisions that should be made at each stage;
3. Departmental stage models specify to the particular departments or functions of the organisation that undertake the development process;
4. Conversion process models transform inputs, such as functions and knowledge, into outputs, such as new products and processes;
5. Response models focus on the organisational reaction to changes that happen in the environment. Such models emphasise the stimuli of the environment in order for firms to generate ideas for new product development. These models concentrate mainly on the decision of whether the new idea will be accepted or rejected;
6. Network models focus on the relationships between actors, activities and resources. The new product is developed through transaction activities between actors and resources.

2.2.6.1 Models for product innovation

New product researches describe the development of a new product as a linear and organised process that flows from idea generation to the commercialisation stage (e.g. Becker and Egger, 2013; Stevens and Dimitriadis, 2005). Cooper (1988), who was among the first scholars to carry out a study focusing on new product development, argued that parallel processing is essential in a product development process, as products’ life cycles become shorter and shorter. This suggests that development processes are implemented quicker than before. It does not indicate that firms should bypass stages or compress the process, but rather that implementing some stages at the same time saves time and resources. This results in a complete and quality new product process. Additionally, as market orientation enhances new product success and pre-development activities determine the quality and performance of the new outcome, they should be both included in the development process (Zhang and Duan, 2010).

Putting all these together, Cooper (1988) developed a systematic process model (Figure 2.7), which involves a series of stages-activities and a gate system that is used to ensure quality and control the process. It should be noted that parallel processing is a feature and marketing and pre-development activities are included in the process.
On the other hand, Saren (1984) criticised existing normative models of new product development, on the grounds that the development process is not linear and sequential, but iterative and recursive. Moreover, highly competitive environments have led firms to implement faster and more complex processes. This is consistent with Crawford and Di Benedetto’s (2011) study, which suggests parallel processing. Additionally, Stevens and Dimitriadis (2005), who carried out a study aiming at offering comprehensive insights into the development process for financial products, summarise three major weaknesses of the sequential models. Firstly, stage-gate models are largely bureaucratic processes that require much time to develop. Secondly, though it is widely mentioned that multi-functional teams benefit the development process; those stages do not describe how firms organise such service development teams. Thirdly, linear models do not provide a clear definition of the product during each stage. Saren (1994, p. 639) adopted a different approach to address those limitations. He developed a set of ‘blocks’ of activities where the sequence is indicated by the direction of the ‘arrows’ (Figure 2.8). Furthermore, the activities that are executed by external partners are shown by shaded areas, while those activities that are implemented jointly with the firm are indicated by half-shaded blocks.
The “blocks” approach provides a flexible sequence of activities during the development of a new product. Activities can also be performed recursively and partially, while development activities can be repeated or completed at a later stage. This approach promotes parallel processing and can be adapted for application to many different kinds of new product development. In addition, it allows external partners to be involved in the process, resulting in an integrated process, as compared to stage models. Finally, pre-development activities are included, as the initial stages are ‘stimulus’, ‘search’, and ‘initial research’. Altogether, this model adopts a more holistic approach than other product development models; it would be interesting to examine its application to service industries.
2.2.6.2 Models for service innovation

Several researchers undertook studies to fill the gap between new product and new service development, as the latter offered offer less comprehensive insights and fewer development models (e.g. Kindström et al., 2013; Rubalcaba et al., 2012). One of the first studies was by Scheuning and Johnson (1989), who conducted in-depth research on financial institutions, focusing on new service structure and new service process. Their intention was to develop a systematic model for new service development. The proposed model (Figure 2.9) consists of fifteen steps, which are grouped into four phases:

1. The direction phase includes the first three steps of the model. The formulation of objectives and strategy govern the development process. Scheuning and Johnson (1989, p. 28) state “…a well-designed new service strategy drives and directs the entire service innovation effort and imbues it with effectiveness and efficiency.” Then, the idea generation step comes in, to elaborate the environmental constraints and opportunities that arose from the new service development strategy, to generate specific service ideas. Idea screening is now deployed to evaluate those ideas and keep the promising ones. Next, the design phase includes seven steps. First, there is concept development, which is actually the expansion of the surviving ideas. A concept is a description of a potential new service, so the firm should consider customers’ needs, potential difficulties, and so forth. Each concept will be assessed by prospective buyers, during concept testing. The aim of this step is to gain information about how customers would react to the potential offerings.

2. For those concepts that successfully pass, business analysis is responsible for assessing the market and advising on a budget for the development and commercialisation of the new service. Then the top management team decides which concept should be developed and commits the necessary resources, through project authorisation. In that case, this is the right time to design and test the new service. In this stage, participation of front-line employees and customer involvement are crucial (see Section 4.2), as the former delivers the new offering and the latter purchases it. Another important aspect is to design the delivery process and system in detail. As services are intangible and inseparable, production and delivery happen.
simultaneously, so it is critical to implement smooth delivery; a marketing programme should be formulated and tested to ensure that all the employees (personnel training) are familiar with the new service and know how to promote it effectively.

3. **After that comes the testing stage.** Service testing ascertains the acceptance of the customers and pilot run ensures that the entire development process operates satisfactorily. If this is not the case, then improvements can be made at any of the stages to amend its functioning. Test marketing, on the other hand investigates whether the current marketing mix is efficient or modifications should be made to bring more customers to the firm.

4. **The final stage is the introduction of the new service offering to the market place.** When the organisation is certain that the development process has functioned smoothly and that customers are well aware of the new outcome, then the firm launches the new service. A post-launch review is also necessary to ensure whether the objectives are attained or further refinements should be made. However, the findings cannot be generalised, so further research and model testing in other service industries should be conducted.
Likewise, Johnson et al. (2000) suggested a new service development cycle (Figure 2.10), describing the development process as a sequence of four stages and twelve activities that should be implemented to develop and commercialise a new service. This includes the constitutive elements that contribute to the process, such as people, products, technology, and systems.
Similarly, Stevens and Dimitriadis (2005, p. 191) developed a systemic model for financial services focusing on organisational learning, which seems to be essential for the success of innovation projects. They included some learning actions that benefit the effectiveness of the model. The model (Figure 2.11) consists of five actors, namely interactors who create knowledge by constant interaction with each other. These interactions create the dynamics of both new service development and organisational learning. The concept of interactors applies to individuals and groups within organisation. Apart from human interactors, the model includes the firm’s infrastructure that contributes to the interaction process, as individuals use it to obtain or transform information. This study concluded that technical and physical infrastructure and information systems play a critical role in the design and development of the new service. In addition, the organisation of a firm appears to be vital for the knowledge-building process. Finally, the external environment of the company is of high importance, as it enables the knowledge-building process, providing information about customers’ needs, competitors’ planning, and legal changes. Nonetheless, this model is not without limitations.

Figure 2.10 The new service development cycle (Johnson et al., 2000; Source: Stevens and Dimitriadis, 2005)
It is risky to generalise its adoption to other types of products or services, because it is based on qualitative methodologies and on a small number of cases.

Additionally, Alam and Perry (2002) carried out research on the financial services industry, identifying the stages in the new service development process and addressing the issue of how customers can benefit that process. They developed a framework of ten stages, presenting it in two different models (Figure 2.12). The first is a linear development process and the second involves parallel processing at some stages. It is noteworthy that the researchers added customer input at every stage of the development process (Figure 2.13). However, the study is based on a small number of financial firms, thus the findings should be deemed as tentative, and further research should be established in other types of service industries, such as healthcare. Moreover, the study did not investigate the relationship between customer involvement and new service success.
**Linear model of development process**

1. Strategic planning
2. Idea generation
3. Idea Screening
4. Business Analysis
5. Formation of a cross-functional team
6. Service design and Process system design
7. Personnel training
8. Service testing and Pilot run
9. Test marketing
10. Commercialization

**Parallel model of development process**

1. Strategic planning
2. Idea generation
3. Idea Screening
4. Business Analysis
5. Formation of a cross-functional team
6. Service design and Process system design
7. Personnel training
8. Service testing and pilot run
9. Test marketing
10. Commercialization

**Key:** Rectangle box: sequential stages; diamond box: overlapping/parallel stages

*Figure 2.12 Two models of new service development (Source: Alam and Perry, 2002)*
### New service development stages

<table>
<thead>
<tr>
<th>Stage</th>
<th>Activities performed by the customers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strategic planning</td>
<td>Feedback on financial data.</td>
</tr>
<tr>
<td>2. Idea generation</td>
<td>State needs, problems and their solution, criticize existing service; identify gaps in the market; provide a wish list (service requirements); state new service adoption criteria.</td>
</tr>
<tr>
<td>3. Idea screening</td>
<td>Suggest rough sales guide and market size; suggest desired features, benefits and attributes; show reactions to the concepts; liking, preference and purchase intent of all the concepts; help the producer in go/kill decision.</td>
</tr>
<tr>
<td>4. Business analysis</td>
<td>Limited feedback on financial data, including profitability of the concepts, competitors’ data.</td>
</tr>
<tr>
<td>5. Formation of cross-functional team</td>
<td>Join top management in selecting team members.</td>
</tr>
<tr>
<td>6. Service design and process system design</td>
<td>Review and jointly develop the blue prints; suggest improvements by identifying fail points; observe the service delivery trial by the firm personnel.</td>
</tr>
<tr>
<td>7. Personnel training</td>
<td>Observe and participate in mock service delivery process; suggest improvements.</td>
</tr>
<tr>
<td>8. Service testing and pilot run</td>
<td>Participate in a simulated service delivery processes; suggest final improvements and design change.</td>
</tr>
<tr>
<td>9. Test marketing</td>
<td>Comments on the marketing plan; detailed comments about their satisfaction of marketing mixes; suggest desired improvements.</td>
</tr>
<tr>
<td>10. Commercialization</td>
<td>Adopt the service as a trial; feedback about overall performance of the service along with desired improvements, if any; word of mouth communications to other potential customers.</td>
</tr>
</tbody>
</table>

*Figure 2.13 Customers’ input in new service development process (Source: Alam and Perry, 2002)*

### 2.2.6.3 Models for service innovation in healthcare

There are a small number of studies in the marketing literature regarding the health services industry. In particular, few researchers have focused on health service marketing, developing
models or frameworks for the service development process (Sharma et al., 2014; Fox et al., 2014). Bowers (1987) was the first to perform extensive research on a large number of hospitals, based on Booz et al.’s (1982) model of new product development. He suggested that hospitals should not adopt bureaucratic approaches to new service development, but instead should implement systematic market-driven processes that will offer them competitive advantages. Healthcare institutions should be sensitive to patients’ wishes and stakeholders’ requirements. His research was the first to discover that hospitals do not use external inputs to new service development, so their new services may not meet customers’ needs. He used those results to develop a normative market-driven model of new service development for hospitals (Figure 2.14), putting forward that hospitals should develop a business strategy to set the strategic orientation of the organisation and prepare for the development of the new service strategy. This leads to the exploration of opportunities and to the initial evaluation of the new service ideas. Next, a formal process of idea generation should be adopted, combining external and internal inputs. This leads to the development of new service concepts, which are evaluated by employees, doctors and potential customers. Business analysis is the next step, where the development team screens the surviving concepts and evaluates their potential performance.

Subsequently, the development and evaluation of the new service is performed with the support of contact personnel (therapists, nurses, paramedics) and customers (patients, relatives). Market testing is also a critical step, as it evaluates the marketing mix that the management team has chosen. This step is the last opportunity to assess the entire development process and make the necessary modifications. The last step is commercialisation of the new service offering in the market. Front-line employees undertake the responsibility for offering superior value to customers. This model illustrates a simplified and linear process; it therefore has the same kind of drawbacks as other sequential models, and does not address many other issues, such as cross-functional team working, up-front activities, and post-launch review.
A study that is worth discussing was carried out by Windrum and Garcia-Goni (2008). They combined the characteristics approach of Saviotti and Metcalfe (1984) with Gallouj and Weinstein’s (1997) competencies framework. The purpose was to build a multi-agent framework that involves, on one hand policy makers, and service providers and on the other, firms and consumers (Figure 2.15). They also applied Barras’ theory (1986, 1990) to interpret the multi-agent framework as a new health services model. This framework includes Schumpeter’s five types of innovation: organisational, product, market, process, and input.

First, the multi-agent framework highlights the actors’ competences and preferences, where technology is the medium through which multiple agents communicate. Although medical technology is important at most health services (e.g. not that important in mental health or withdrawal services), the competences of health professionals, and their interactions with patients determine service characteristics (Windrum and Garcia-Goni,
Second, although policy makers are not service providers, they have an enhanced role in the provision of health services as they make major decisions about public health. They actually draw up the framework within which service providers operate. What is more, patients are a critical actor in service development, especially in healthcare environments. Even though users’ preferences and competences have not been widely explored, it is matter-of-course that patients should be fully aware of their treatment. Additionally, it has been mentioned in the literature that customers’ decisions are also influenced by the family or social group to which they belong (e.g. Elg et al., 2012). Moreover, there are service provider competencies, distinguished as user-facing or back office. The former refers to skills, expertise, and technologies that define, produce and deliver the new service in interaction with users. The latter considers skills and administrative techniques that support user-facing competences and activities. It should be noted, here, that although the model is applicable to types of services other than healthcare, it focuses on knowledge-intensive industries so further research should be carried out in human and physical capital-intensive sectors.

Figure 2.15 Operationalised model with user-facing competencies and back office competencies (Source: Windrum and Garcia-Goni, 2008)

More recently, Duncan and Breslin (2009, p. 14) presented an innovative new health service development programme that has been developed and adopted by the Mayo Clinic. The
programme consists of a four-step human-centred process. First is the topic-framing step, where a general subject is explored to develop an essential understanding of the issues and relationships related to the empirical practice of that subject. The aim of this step is to call all stakeholders to decide the direction of the project and share it with the project team. Then, there follows the research step, where data are collected through field observations, interviews and mediated questioning tools. Researchers and strategists cooperate to identify opportunities and challenges. Third is the design and development step, where researchers are called on to generate ideas through multi-system approaches and develop new concepts. These approaches often combine novel ideas related to people, resources, technology and so on. Then the new concepts are evaluated by real patients and clinicians as an effort to determine their value and describe the clinical experience. This provides the firm with the necessary information about the performance of the new service before its final launch. Both research results and design tools are used by the organisation to understand human behaviour and this understanding becomes a locus for innovation. Finally, there is the implementation step, where the new service is launched. A researcher keeps up with the new offering in a consultant role to review the new service and its development process. Although this is a simplified model for new service development in the healthcare industry, it is probably the first in the literature that describes a user-oriented process, which is developed and used by the largest multi-specialty non-profit organisation in the world.

Although Bowers model is the first attempt of describing a formalised service innovation model, this study adopts the multi-agent framework of Windrum and Garcia-Goni, (2008), because it incorporates the entire spectrum of the participating stakeholders in the service development process. As it is mentioned above, policy makers, suppliers, customers, and employees play a critical role in health service innovation as well as the interactions among them, for example the competences of health professionals and their interactions with patients determine service characteristics, therefore affect customer experience. Considering the required multiperspective approach of health service development, it is seen that the one-sided stage gate models for product innovation would not suffice for the successful development of services for the healthcare market.
2.3 Customer involvement in service innovation

This section defines customer participation in service innovation, presents its different types that affect the success of new service development as well as shows the role of customers. It also discusses the limitations that emerge from customer involvement.

2.3.1 Definition of customer involvement

Nowadays, studies show that customers wish to be involved in firms’ innovation activities (e.g. Sindakis et al., 2015; Cui and Wu, 2015). Djelassi and Decoopman (2013), and Chen et al. (2015) have described that customers are interested in participating in the product or service development processes so as to ensure that the final offering will satisfy their needs in the best possible way. A prerequisite of customer involvement in such processes is the companies’ openness and willingness to have their customers taken part in their innovation activities. Despite the concern of many business executives who claim that the companies’ innovation plans are confidential; many firms choose to let their customers to participate in new product or service development in an attempt to gain insights that will allow them to build competitive products for the market. Consequently, an antecedent of customer involvement is the company’s decision to adopt a customer orientation approach, wishing to integrate its key technological competencies with the insights of the customers. This approach also applies to healthcare organisations, which develop and adopt methods that allow the integration of patients in their service development activities, developing relationships of trust and loyalty with their customers.

Customer orientation was first mentioned by Drucker in 1955, when he pointed out that the purpose of a firm is to create and keep customers. Since then, several scholars have attempted to analyse and elaborate this notion, arguing that firms should make efforts and plans to apprehend customers’ needs and accomplish those needs by developing specific products and services (e.g. Blocker et al., 2011; Tajeddini, 2010). Many studies describe customer orientation as a unique capability of organisations to innovate, developing successful offerings and achieving competitive performance (e.g. Korschun et al., 2014; Feng et al., 2012). In addition, Slater and Narver (1998), and more recently Witell et al. (2011) suggested that companies should implement different and interdependent market research
techniques, such as customer observation, experimentation, and selective partnering. This allows firms to ascertain customers’ needs and supply them with the proper products, creating, at the same time, superior customer value. Customer value is defined by Holbrook (1999, p. 5) as “an interactive relativistic preference experience.” Zeithaml (1988, p. 13) identifies four diverse meanings of value as: (1) low price, (2) whatever one wants in a product, (3) the quality that the consumer receives for the price paid, and (4) what the consumer gets for what they give up. Likewise, Witell et al. (2011), who performed a study to appreciate the differences between proactive and reactive market research techniques throughout the new product development, introduced the term “value-in-use”, supporting a view that that consumers automatically contribute to value creation. They (p. 7) claim “…value is determined by and can only be created with the customer in the consumption process through use, and involves customer participation in the creation of the core market offering itself.”

It is also widely recognised that customer-oriented businesses heighten customer satisfaction and deliver better service quality (e.g. Malhotra and Kubowicz-Malhotra, 2011; Fuchs and Schreier, 2011; Hoyer et al., 2010). For example, Malhotra and Kubowicz-Malhotra (2011, p. 44) characteristically report, “Firms are collecting more information about their customers than ever before in an attempt to understand and better serve customer needs.” Yet, Wikstrom (1995), Magnusson et al. (2003), and Kotler (2011) argue that customer orientation is the key to achieving organisational goals and a useful source of new ideas, as it affects product quality. Similarly, Fuchs and Schreier (2011), who investigated how mass customers realise customer empowerment strategies, highlight that customer involvement provides organisations with a beneficial corporate outlook and positive behavioural intention, such as purchasing loyalty and corporate commitment. As regards customers’ point of view, a study by Hoyer et al. (2010), which developed a conceptual framework that focuses on the degree of consumer co-creation in new product development, argues that consumers are able and willing to provide ideas for new offerings that would fulfil unmet needs. Similarly, Kwan and Yuan (2011) developed a framework for establishing a customer-driven philosophy and points out that organisations should have a clear understanding of the customer orientation concept. Otherwise, they can be led to ineffective plans and cursory changes in organisational practice that could jeopardise their future.
It seems, however, that a small number of studies have attempted to define customer involvement. For example, Deshpande et al. (1993, p. 27) adopted a philosophical point of view, stating that customer orientation is “the set of beliefs that puts the customer’s interest first, while not excluding those of all other stakeholders...to develop a long-term profitable enterprise”. Matthing et al. (2004, p. 487) focused on methods, efforts and dealings that the service provider utilises to identify customers’ needs, while Hoyer et al. (2010) employ the term co-creation to describe the active participation of consumers in a new product development process. They mention that customer involvement enhances product quality, reduces risk, and increases market acceptance, because ideas generated through co-creation process are likely to meet customers’ needs. Likewise, O’Herm and Rindfleisch (2009, p. 4) define co-creation as “a collaborative new product development (NPD) activity in which consumers actively contribute and select various elements of a new product offering.” Additionally, Gatignon and Xuereb (1997, p. 78) carried out a study that focuses on the relation of strategic orientation of the firm and product performance. Given that customer orientation is one of the three strategic orientations that determine the success or failure of new offerings, they (p. 78) define customer-oriented firms as those “with the ability and the will to identify, analyze, understand, and answer user needs.” The definition of Hoyer et al. (2010) for customer involvement will be used in this study, as it considers customer participation in new product development as an active and ongoing process, allowing the stakeholders, not only to provide the company with their opinion, but also to co-create the product with the firm. This process is particularly important in healthcare as patients want to make sure that they get the best possible treatment. As discussed in sections 2.4.3 and 2.4.4, the ability of patients and their families to acquire relevant knowledge regarding health issues and potential solutions through different and rich means is a reality today and has become of paramount importance for them, affecting the ways that doctors and hospitals operate.

2.3.2 Types of customer involvement affecting service innovation

Organisations continuously seek to exploit new opportunities, generating ideas and bringing them to the market place (Chesbrough, 2003). As highlighted earlier, customer participation can be a good source of information and knowledge (e.g. Jean et al., 2014; Lau, 2011) particularly in service firms, enhancing service effectiveness (Stock and Dreher, 2012;
Hillebrand et al., 2011). Hoyer et al. (2010, p. 292) agree that companies can generate two valuable sources of competitive advantages when they successfully implement consumer involvement. One is referred to as productivity gains through increased efficiency (e.g. by condensing functioning expenditure), while the other as enhanced effectiveness (e.g. through an improvement in the value of a product, innovativeness and learning capabilities, and a better fit with consumer needs). In addition, Jeppesen (2005) carried out a research to explore what happens when firms pass design tasks on to consumers. He discovered three approaches regarding the level of consumer involvement in product development: listening to consumers, interactions with advanced users and user tool kits for innovation. Likewise, several other studies have attempted to categorise customer participation (e.g. Lin, Tu et al., 2013; Vivek et al., 2012), but few have managed to clearly describe it. A study by Eason (1995) divided customer orientation into three categories. The first category concerns designing and developing a service for customers without their intervention, obtaining information from traditional sources, such as market research, customers’ behaviour and so on. The second relates to the designing and developing of specific services with the participation of users, considering their preferences and focusing on their needs. The last category considers customers as producers, designing and developing their own services.

This leads to the assumption that the users of a service can take different roles, creating economic value for the organisations who promote customer orientation and exchanging resources to be innovative (Ngo and O’Cass, 2013; Piller et al., 2010). Moran and Ghoshal (1999, p. 409), who developed a framework to portray value creation as a process that includes resource combinations and exchanges, agree that “…it is not resources per se, but the ability to access, deploy, exchange, and combine them that lies at the heart of value creation”.

2.3.3 Limitations emerging from customer involvement

Several studies have indicated the risks of customer orientation (e.g. Homburg et al., 2011; Cook, 2008). For example, Ordanini and Parasuraman (2011) carried out a study on service innovation and found that customer involvement adds to innovation level, but is not likely to encourage radical innovation. Firstly, it is critical to mention that changes might be negative or undesirable. For instance, doctors and psychologists argue that excessive exposure to
television programmes and video games can be harmful to children’s physical and mental health (e.g. Christakis et al., 2004; Caroli et al., 2004; Vandewater et al., 2004; Pfefferbaum et al., 2003; Van Evra, 2004). Secondly, nothing can guarantee that the outcome will be successful, e.g. many patients go through unsuccessful surgical operations. Thirdly, products and services that are not used properly will not lead to alterations in the user’s behaviour or state. If a student, for example, does not study carefully during his/her course, then the result will be a less-educated person than another who took the course more seriously. Thus, companies should provide facilities, motivation, and encouragement to their customers, as they need to show that their intermediate products and/or services are efficient. In addition, Hoyer et al. (2010, p. 292) explain some different costs and risks of consumer co-creation. First, firms need to transfer control over innovation processes to selected customers and this may put at risk the firm’s strategic plans. In addition, the development process might be complex in balancing a company’s aims with the interests of shareholders, employees, co-creators and other types of customers. Yet again, advanced participators can become, in some cases, a source of competition, as they may develop challenging versions of the new offering (e.g. in software development), resulting in damage to brand image and loss of product sales (Romero et al., 2014; Hunt et al., 2012). Lastly, every effort to control independence of partakers will diminish their enthusiasm for contributing and augment the danger of customer apathy (Krug et al., 2010).

On the other hand, we should consider the reasons for which the customers are interested in participating, sharing information, and spending time over a firm’s problem. Hoyer et al.’s (2010) research mentions that customer participation requires some monetary and non-monetary resources, such as time, physical and psychological effort, to contribute to the new service development process. In proportion to these expenses, Etgar (2008), O’Hern, and Rindfleisch (2009) underline that contributors balance gains of engaging in such activities. Likewise, Foss et al. (2011) argue that this kind of customer-firm interaction provides participants with some product-related tangible and intangible benefits as well as a sense of belonging and identity. This transforms customers’ behaviour as they feel that they have the power to influence the firm’s decisions over the development of a new product. The studies by Hoyer et al. (2010), Nambisan and Baron (2009) agree with this, reporting numerous factors that stimulate customers to participate in the development of new offerings: financial
rewards, such as monetary prizes or profit sharing from the firm; technological knowledge by participating in forums organised by the developer, and so on. In contrast, other consumers are not satisfied with such rewards, but seek social returns. On one hand, Nambisan and Baron (2009) state that social benefits consist of increased status, social esteem and “good citizenship,” while on the other, Claudy et al. (2014), and Schreier et al. (2012) illustrate psychological effects of this interaction, such as self-repute, enhanced self-esteem, altruism, reciprocity, etc. Similarly, Ernst et al. (2010) noticed that some customers might be willing to join the development process because of great concern or disappointment about the present offering.

At this point, there should be mentioned the expenditure necessitated by efficient and effectual patient involvement. Tobin et al.’s (2002) is probably the only study that looks at patient participation from this perspective and distinguishes two kinds of spending here, direct and indirect. Direct expenditures refer to the money spent on employing a patient co-ordinator; endorsing patient-based initiatives or paying service users for their contribution to the service development process. Indirect costs comprise staff resources absorbed by maintaining patient involvement initiatives; time costs for clinicians participation in non-clinical activities; staff training activities; location utilisation costs, equipment, and travel expenses for service users to be present at meetings.

Customer roles affecting the success of service innovation

The review of the literature has provided a number of roles that service customers can adopt so as to provide valuable insights for the service innovation process, assisting the companies to overcome many of the above-mentioned barriers and limitations. For instance, Greer and Lei (2012), Gustafsson et al. (2012), Kuusisto and Riepula (2011) have identified that customers can act as a: resource, co-producer, buyer, user and product. The first two customer roles are at the upstream, and the next three are at the downstream end of the value creation process (Lundkvist and Yakhlef, 2004; Nambisan, 2002). Hoyer et al. (2010) distinguish co-creator consumers as innovators, lead-users, emergent consumers, and market mavens.

As emphasised earlier, service customers can be a mine of useful information and knowledge, leading to novel ideas and providing competitive advantages to the firms (Newton
et al., 2013; Smith et al., 2011). This is valid for healthcare organisations as well. Naidu et al. (1999) conducted a research project investigating the approaches to relationship marketing that hospitals adopt and connect these approaches with their overall performance. They concluded that healthcare organisations should meet the needs of the population, cooperating with various groups of customers - such as therapists, patients, payers, etc. - to develop and implement customer retention programmes that enhance service quality and customer satisfaction. These programmes include post-treatment satisfaction services, frequent user benefits, patient-focused care programmes, support for on-going relationships with customers, and other programmes that involve customers in the design, development, and sales activities of the healthcare organisation (Entwistle et al., 2012; Owens et al., 2011). Nevertheless, it has been clear in the management literature that many factors influence customer-organisation interaction in such a way that this may be beneficial (e.g. Hjelmgren and Dubois, 2013; Lin and Huang, 2012). For instance, Nambisan (2002, p. 394) argues that customers are an excellent source of innovation, when the maturity of technology and the alignment of a product line with the current customer base are high, while this does not stand when both elements are low. In this case, customers’ opinions and suggestions lead to imitative and commonplace solutions. This is consistent with the view of Cook (2008) discussed above that sometimes the outcome might not be successful or radically new. The companies shall therefore involve their customers when they are familiar with the company’s operations, products, and business mission. Likewise, Bitner et al. (1997) and recently Lee et al. (2011) found that customers affect both the quantity and quality of the production process. Studies by Storbacka and Pennanen (2014), Mende (2013), and Azad and Esmaeili (2012) therefore suggest that firms should locate those lead customers who are able to provide them with useful information and promote them to partial employees, maintaining a good relationship and balance between the shareholders, other co-creators and customers. Additionally, firms should motivate those customers to be productive (Machado et al., 2014).

Other studies underline that customers can participate substantially in the design and/or development process of a service, as co-designers and/or co-producers (e.g. Fischer et al., 2013; Ardito et al., 2012). This indicates that customers will not only provide the organisation with information related to their needs and wishes, but will also be actively involved in the production process by choosing suitable design solutions and specifications of
their interest (Field et al., 2012; Nambisan, 2002). Veryzer and de Mozota (2005) conducted research to analyse user involvement in new product development processes. They found that user-oriented design benefits new product development, as highly customised superior products/services lead to successful innovation (Figure 2.16). By taking the role of co-designer or co-producer, the customers maintain their interest in the innovation process, limiting the possibilities of customer inertia and apathy, as this is described in Krug et al.’s (2010) study.

Figure 2.16 User-oriented design impact on new product development (Source: Veryzer and de Mozota, 2005)

However, despite the potential gains from this kind of cooperation, firms should be aware of the potential risks. Stock (2014), Jiménez-Zarco et al. (2011), and De Faria et al. (2010) set out the most important threats: an increase in the level of uncertainty; implicit costs that the co-creators might need to understand when using the technology; the (lack of) connection between them and the new service development team. Furthermore, Lengnick-Hall (1996) indicates the buyer role as the middle stage between potential customer and service user. Many researchers argue that the relationship between organisation and customer and the quality that the customer receives are the two major factors that direct the potential customer to make the purchase of the service (e.g. Edvardsson et al., 2012; Oliveira and von Hippel, 2011). Therefore, companies should invest on these two values to build a good reputation, as
it is well known that customers share their experiences with potential customers directly or indirectly (Bogers and West, 2012).

An additional role played by customers is that of contributor to quality, satisfaction, and value (Udo et al., 2010). At this point, users produce an internal and an external outcome. The internal outcome is the satisfaction that they obtain using a product or a service, while the external is that they are able to raise competition in an industry, requesting products of higher quality (Eberly et al., 2011). An internal outcome is a matter of customer satisfaction after using an offering; studies define it as an after-purchase judgement that attributes user satisfaction when the result meets or exceeds customer’s expectations (e.g. Raja et al., 2013; Flint et al., 2011). Bitner et al. (1997, p. 197) add that the “effective customer participation can increase the likelihood that needs are met and that the benefits the customer is seeking are actually attained”. An external outcome, on the other hand, concerns the demand for quality. Customers often challenge companies to raise quality and enhance the product range. This indicates that the knowledge that customers have about the system acts as a stimulant for the development of expectations that are challenging but achievable (Belkahla and Triki, 2011). This approach minimises the risk for customers to become competitors as they are actively engaged in the innovation process.

In spite of the positive factors and results above, there are certain challenges that organisations should take into account. Firstly, it is crucial for firms to develop professional and creative relationships between users and the product development team, and secondly, companies should balance the satisfaction of customers with other components of the system, such as investment needs, third-party payers, intermediate customers, and so forth (Haverila et al., 2013; Fuchs and Schreier, 2011). Apart from these two outcomes, Nambisan (2002) suggests that users contribute to product testing and product support. Customers who participate in product testing process provide the firm with valuable information about effectiveness, usability, and so on. Moreover, customers with experience in using a product or a service can function as supporters by sharing their knowledge with other users. However, two important limitations should be acknowledged. Firstly, organisations should ensure they involve different kinds of customers in product and pilot testing processes. This allows them to gain information from various sets of users, covering a wide range of demands, needs, and
wants. Secondly, firms should decide whether they are ready to provide all the necessary resources to customers to obtain maximum inputs from users (Williams and Naumann, 2011). Finally, there is the product role that the customer might adopt. This happens when a customer is crossed with a process that he/she has paid for. For instance, when a person chooses to study and pays fees to a school, he/she becomes an educated person. That customer is now the product of the transformation process.

2.4 The relation between corporate venturing and customer-driven service innovation in healthcare

Corporate entrepreneurship is a term encompassing various organisational acts aiming at creation, renewal, or innovation. It embodies a number of entrepreneurial efforts such as corporate venturing (Battistini et al., 2013), internal resources (Mainela, 2012), internalisation (Verbeke et al., 2014; Onetti et al., 2012) and external networks (Titus et al., 2014; Slotte-Kock and Coviello, 2010). The above analysis implies four domains in which a company can concentrate its entrepreneurial efforts towards innovation. Although very different, these domains are all rooted in organisational resources. Sirmon et al. (2011), and Barreto (2010) stress that in order for the organisation to achieve diversification through internal development, new resource combinations are required which present the potential of exploiting areas of organisational activity unrelated or marginally related to the organisation’s current domain of competence.

Ireland et al. (2003) introduced the importance of ‘top management teams and governance’, explaining that organisational leadership and performance is enhanced through the strategic and entrepreneurial use of the intellectual capital of the organisation’s force. If anything, top management teams’ influence can be paramount, translating a shared vision into goals and strategies. However, this approach focuses on the role of top management, reward systems and governance as the enablers of innovation and growth, all linked with new processes, products or services, strategic renewal or creating new types of business. While the target and desired outcome is that of innovation, coining a comprehensive term remains elusive. In the literature, it is a broad and often confused term. A strand of research has deemed innovation as a process (Chang, 2011; Seelos and Mair, 2012; Adams et al., 2006),
whilst other researchers have equated it with the result or commercialisation of a company’s entrepreneurial activities (Lin, 2011; Agarwal and Selen, 2011). This is a concept considered to be complex and multifaceted, comprising of various events and activities taking place in sequence or simultaneously, which, nonetheless, are expected not only to generate new ideas, but to focus on enhanced performance and sustainable competitive advantage which can set the organisation ahead of competitors in the long run (Andreeva and Kianto, 2012; López-Nicolás and Meroño-Cerdán, 2011; Silberstang and Hazy, 2008). It is determined by both internal factors, which characterise the organisation and external conditions of the market in which the organisation operates.

In the challenging global landscape, which requires companies to respond to change with adaptability to benefit from these shifts, and emerging opportunities in the global market, new collaborations and partnerships are of paramount importance. This strategic approach can foster simultaneous innovation at multiple points; collaboration between businesses, government departments, research institutions, funders, and investors could really be a catalyst for exchanging new forms of knowledge and sharing cutting-edge business innovation. In this instance, new opportunities arise in the form of novel products, services, systems or in the form of incremental improvement in existing methods, products and so on. Drucker (1985), and more recently, Leydesdorff et al. (2013) identified an array of discrepant processes, industrial structures, market demographics, changes in perspective and knowledge as the source for emerging opportunities leading to innovation. On the other hand, Brem and Borchardt (2014), and Kornish and Ulrich (2011) emphasised the key aspect of successful (commercial) application and launching of novel ideas to the market in a way that is consistent and systematic. In this scope of the topic of ‘innovation as a development continuum’ fuelled by relentless investment in research and technology advancements, innovation involves investment expenditures which are not guaranteed to yield secure returns in the future.

Martinelli et al. (2013), and Bao et al. (2012) labelled this approach to innovation as the market experiment and predicted that it would bring about sweeping changes and restructuring across industries and markets (Schumpeter and Fels, 1939). Close collaboration, new forms of partnerships and knowledge networking can result in inter-organisational
learning and dissemination of new, valuable information. Several studies have underlined the importance of participating in such networks because of the key growth factors they offer such as access to new forms of information, reliability, and responsiveness to change (e.g. Cooke, 2013; Salavisa et al., 2012; Carayannis and Campbell, 2012). Collaboration between the private sector and research institutions resulted in innovation driven start-ups in the 1990s to early 2000s, especially in the United States. Below the four perspectives on corporate entrepreneurship are described.

Corporate venturing

Corporate ventures can be seen as a systematic organisational method for competence development in relation to research and development activities, competence acquisition or joint development with other firms. The effects of corporate venturing are linked with corporate entrepreneurship, organizational learning, and innovation management with other firms (Battistini et al., 2013).

A study by Burgelman (1985) coined the term ‘New Venture Division’ to describe the joint entrepreneurial effort by different individuals to create new businesses. Since then, scholars have ventured many different definitions of the entrepreneurial activities that make up of what we call corporate venturing (e.g. Vega et al., 2013; Lin and Lee, 2011). Dedicating resources to corporate venturing is motivated by the desire to curb the bureaucratic structures and formal procedures of a large company. Investing in corporate venturing allows participating companies to exploit market opportunities, reduce risks, acquire licenses of promising technology, identify appealing acquisition targets, all of which create opportunities for strategic innovations.

Internal resources and internationalisation

Recent advances in technology innovation and science in conjunction with global capital movement have influenced industrial activity, creating new industries while displacing others. In this new fast changing environment, healthcare firms need to invest in their intellectual capital and create an intangible asset class as a key factor to their sustainable advantage. While tangible resources are easily accessible or subject to imitation by rivals, intangible resources is an invaluable capital asset leading the firm to intra-organisational achievements
and significant financing mechanisms. Hussi (2004), Kramer et al. (2011), and Lerro et al. (2012) have stressed the potential of turning intangible knowledge assets into commercially exploitable intangible assets. This aspect of intangible resources is very important to corporate entrepreneurship, as also emphasized by Anderson and Eshima (2013), and Hitt et al. (2011).

The strength of intangible resources lies in coordinating existing, tangible resources to generate innovations and competitive advantage and secure thus continuous business development. In advanced technology sectors especially (e.g. healthcare), the skill and intellectual capital embedded in the company’s workforce may be the ultimate acquisition goal. To create knowledge-based value, intangible assets must be applied and integrated in a way that allows knowledge sharing and data dissemination across different parts of the organisation, as well as the identification, and exploitation of new commercial possibilities, all of which are crucial factors enabling innovation within organisational boundaries. The physical and conceptual structures of the organisation should operate in way that facilitates the support, enhancement, and intra-firm distribution of its human capital (Guerrero and Peña-Legazkue, 2013). This is a value platform model in which human capital aims to strengthen internal structures, manage and coordinate relational dimensions of business activity and exploit external market opportunities. An effective such model is one that pulls these dimensions into closer interaction with each other. The intersection of human capital, internal resources, and external structures forms the basis for value creation (Grimaldi et al., 2012; McGrath et al., 2012). The above internal resource perspective constitutes a promising potential for corporate entrepreneurship, especially in the healthcare industry.

External networks and knowledge acquisition

Successful companies create sustainable value through the combination of both tacit and explicit knowledge, expertise and awareness of external realities. This approach entails converting existing knowledge (implicit or explicit) into larger knowledge structures, which is systemic knowledge (Nonaka and Takeuchi, 1995). Building long-term value is all the more critical for organisations operating in the healthcare sector as securing high quality of care is of fundamental importance. Such a model would provide a platform for consolidating business growth in a sector admittedly fragile, and highly fragmented, such as healthcare.
Individual companies do not have the financial strength to invest in new forms of technology, systems, and knowledge and thus are met with a limit of growth, which they can reach. Private equity and corporate venturing enable companies to achieve economies of scale based on sharing management capacity, access to capital and risk taking.

2.4.1 Customer dynamics in service innovation

Several studies have noted that services involve customers in their production and delivery owing to the interaction (information and/or effort) between service provider and user (e.g. Bolton and Christopher, 2014; Lin and Lin, 2011). Hence, customer orientation appears to play an important role, particularly in service firms, because of heterogeneity, inseparability, intangibility, and perishability (Tajeddini, 2011; Jaw et al., 2010). Although customers do not pay much attention to this interaction, service firms should reconsider their strategies and appoint lead customers as organisational members or partial employees (Witkowska and Lakstutiene, 2014; Blocker et al., 2011). This is associated with what has been written in the strategic marketing literature. Many scholars argue that customer involvement is critical for the acquisition of sustainable competitive advantages, which lead to business profitability (e.g. Prahalad and Ramaswamy, 2013; Svendsen et al., 2011; Feng et al., 2010). Therefore, the question is how service firms should develop a successful customer orientation.

Gouthier and Schmid’s study (2003, p. 132) suggests that companies should implement a strong customer orientation throughout the firm and not only in customer-related functions. Given that the ultimate goal of every organisation is to create and keep customers (Drucker, 2012), service firms should manage to have their focus and resources turned towards them. Practically, this signifies that companies should include this intention in their strategy, structure, organisational culture, information systems, and human resources. Nwankwo’s study (1995) goes a step forward and advises firms to create a high customer-oriented profile through the development of a value system (Figure 2.17). This allows the entire organisation to become more responsive to the demands of its customers, thus, firms should define the needs of their customers well to satisfy them. Companies should also be perceptive, proactive, and flexible as to future expectations or problems that might come up. What is more, companies should attain measurement validation using formal tools that provide feedback on whether customer needs are included in the programmes and how these
customer orientation programmes are implemented. Finally, the interpretation of those
programmes into action is vital and therefore, is divided between responsibilities (where the
staff is chosen) and tasks that pertain to organisational systems, procedures, and interactions.

![Diagram of Customer Orientation](image)

**Figure 2.17 A framework for auditing a customer orientation profile (Source: Nwankwo, 1995)**

Studies by Laage-Hellman and Lind (2012), and Sigala (2012a) underline that firms have to
identify customers as being in some sense part of their workforce. This appears to be essential,
because active customer involvement is likely to guide firms to innovative activities, leading
to the possession of competitive advantages. This is supported by both Chen et al.’s (2014),
and Bonner’s (2010) studies. The first reports that companies should consider their customers
as fully legitimate actors and active participants in providing valuable information about their
needs and in suggesting modifications. Similarly, the latter contributes to the marketing
literature, identifying two moderating conditions of customer interactivity and the new
product performance relationship. At one end, formal and impartial resources, such as survey feedbacks and/or formal documents, are used by the development team to obtain information about customers’ preferences, while at the other, frequent meetings between the two groups take place to solve problems. Bonner (2010) also concluded that customer involvement processes that incorporate bidirectional communications, direct customer participation in development projects and joint problem solving, let firms better appreciate customers’ needs and develop successful new offerings. More recently, Witell et al. (2011) carried out research aiming to understand the differences between proactive and reactive market research techniques during the development of new market offerings. They have found that customers are not usually keen to participate in the value creation process and proposed (p. 4) that “…replacing the passive view of customers with an active view, in which customers are invited to use their own initiative rather than simply react to predetermined questions and instructions, will provide new opportunities for companies to create market offerings with greater customer value”.

To sum up, firms should define their product-market orientation and place customers in the thick of it, as many companies fail to meet their customers’ needs (Boso et al., 2012). This develops a creative collaboration between firm’s employees and customers with feedback, suggestions, and new ideas that emerge during their cooperation (Oakley, 2012; Bendick et al., 2010). Nwankwo’s study (1995, p. 8) suggests that, to accomplish this, customer-focused organisations should:

- have clear ideas about customers and their needs;
- exploit customer characteristics, underpinning the design of the product/market portfolio;
- specify customer care objectives and use feedback systems, enabling the organisation to reach its customers and vice versa;
- develop effective customer education/information systems and understand the behavioural nature and consequences of consumption.
2.4.2 Key concepts affecting the success of corporate venturing and customer-driven service innovation

There are different perspectives regarding the factors that are important in measuring the success of service innovation and corporate venturing. Table 2.7 illustrates an inventory of factors represented by categories as key concepts influencing the success of service innovation and used in this study. Research studies by authors (Column 1) are synthesised into categories (Column 2) in Table 2.7, as they are related to service innovation and corporate venturing. Then, these categories were adapted and combined to related key concepts (Column 3) to cover and be relevant to the healthcare providers. These key concepts are used in the development of this study, playing also a key role in developing the questions for the members and executives of the case hospitals (see section 5.2.3).

*Table 2.7 Key concepts influencing the success of service innovation and corporate venturing in this study*

<table>
<thead>
<tr>
<th>Authors of related studies</th>
<th>Categories (Synthesised from related studies and related to Service Innovation and Corporate Venturing)</th>
<th>Key concepts (Adapted from categories for healthcare providers)</th>
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<tbody>
<tr>
<td>Adams et al. (2006)</td>
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<td>Organisational growth and sustainability</td>
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<td>Organisational change and innovation</td>
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<td>Rapaccini et al. (2013)</td>
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The first category (Column 2) is about innovation and innovation management. Innovation takes organisations to a higher level of organisational growth and sustainability. Organisations employ innovation strategies not only to build innovative products to make profits, but also to accumulate know-how and technology skills to enhance its operations. Employees also learn new ways of thinking from these innovations, and then produce more and more innovative products to serve the needs of their customers. Section 2.2.5 gives more discussion about innovation strategies. The second category is about service innovation. Several studies (see the table 2.7 above) have highlighted that the success of service innovation is subject to and also depends on systematic approaches and processes, clear strategies that are communicated to every member within the organisation, and also development of the personnel expertise to build loyal and satisfied customers. The third category regards organisational innovation. It has been clear in the literature (see also Table 2.7) that business culture, organisational structure and risk-taking policies play an important role in the actual development of innovations, and therefore, organisations’ growth and sustainability.

The fourth category is about corporate venturing. Studies have shown that while corporate entrepreneurship enhances firms’ organisational capability to survive and sustain, creating value and adopting a strategic philosophy for innovation, corporate venturing appears to be an important tool for organisational change and renewal. The sixth and the seventh categories are linked to the internal resources as well as to the external networks and knowledge acquisition. The former refers to the intangible resources and capabilities (e.g. knowledge and skills) that improves organisations’ ability to create knowledge-based value leading to business development. Likewise, the acquisition of knowledge and the external networks are valuable to healthcare firms as they enhance their ability to create systemic knowledge, leading also to organisational sustainability and growth. All of these key concepts:
Innovation and innovation management; Service innovation, Organisational innovation, Corporate venturing, Internal resources, External networks and Knowledge acquisition have been investigated in this chapter, and also support the development of the conceptual framework in Chapter 4. The rationale behind each of these key concepts causing the development of service innovation and exploitation of entrepreneurial opportunities is presented in Section 4.2 in Chapter 4.

Similarly, Table 2.8 shows a list of factors characterised by categories as key concepts influencing the success of customer orientation and new service development and used in this study. Research studies by authors (Column 1) are synthesised into categories (Column 2) in Table 2.8, as they are related to customer orientation and new service development. Then, these categories were adapted and combined to related key concepts (Column 3) to cover and be relevant to the healthcare providers. These key concepts are used in the development of this study, playing also a key role in developing the questions for the members and executives of the case hospitals (see section 5.2.3).

**Table 2.8 Key concepts influencing the customer orientation and new service development in this study**

<table>
<thead>
<tr>
<th>Authors of related studies</th>
<th>Categories (Synthesised from related studies and related to Customer Orientation and New Service Development)</th>
<th>Key concepts (Adapted from categories for healthcare providers)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Generation of opportunities</td>
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<td>Gremyr et al. (2014)</td>
<td></td>
<td>Cost reduction and sales increase</td>
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<td>Frambach et al. (2003)</td>
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<td>Value creation</td>
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<td>Loch and Kavadias (2008)</td>
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<td>Menor and Roth (2007)</td>
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<td>Narver and Slater (1990)</td>
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<td>Smith et al. (2007)</td>
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<td>Storey and Hull (2010)</td>
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<tr>
<td>Ardito et al. (2012)</td>
<td>Customer Orientation</td>
<td>Customers’ needs</td>
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<tr>
<td>Belkahla and Triki (2011)</td>
<td></td>
<td>Experimentation</td>
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<td>Blocker et al. (2011)</td>
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<td>Selective partnering</td>
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<td>Bogers and West (2012)</td>
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<td>Customer value</td>
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<td>Bolton and Christopher (2014)</td>
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<td>Customer satisfaction</td>
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<td>De Faria et al. (2010)</td>
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<td>Edvardsson et al. (2012)</td>
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<td>Entwistle et al. (2012)</td>
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<td>Field et al. (2012)</td>
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<td>Reference</td>
<td>Patient Involvement</td>
<td>Patient-focused NSD</td>
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<tr>
<td>Alves et al. (2013)</td>
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<td>Patient’s behaviour</td>
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<td>Ennis and Wykes, (2013)</td>
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<td>Ford and Fottler (2000)</td>
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<td>Patients’ motivation</td>
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<tr>
<td>Gafni et al. (1998)</td>
<td></td>
<td>Organisational improvement</td>
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<tr>
<td>Lammers and Happell (2003)</td>
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<td>Service environment design</td>
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<td>Naidu et al. (1999)</td>
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<td>Knowledge transfer</td>
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<td>Ritchie (1999)</td>
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The first category (Column 2) is about new service development. It is well-reported in this study that NSD leads to business growth, prosperity and sustainability by generating opportunities that will meet customers’ needs, therefore, NSD activities are likely to create satisfied and loyal customers. In addition, the different types of new services are able to help
companies to create value, reduce cost and also increase sales. Section 2.2 gives more discussion about the benefits of new service development. The second category displays how customer orientation addresses and enhances the new service development process. The review of the literature shows the different types of customer orientation and describes how it adds value to the company, by creating products that meet customers’ needs, enhance service quality, and increase customer empowerment. More details can be found in Section 2.3. Similarly, the third category focuses on patient involvement and describes the benefits of this in developing health services that address the needs of patients. Several authors have also noted that patient participation has a positive impact on knowledge transfer within healthcare organisations and also improves their morale and overall psychology, which are both critical in, and many times define, treatments’ success.

All of these key concepts: New service development, Customer orientation, and Patient involvement have been investigated in this chapter, and also support the creation of the conceptual framework in Chapter 5. The rationale behind each of these key concepts causing the development of customer-oriented new services is presented in Section 4.2.3 in Chapter 4.

2.4.3 Critical factors affecting the success of corporate venturing and customer-driven service innovation in healthcare

Corporate venturing creates incentives for improved ways of commissioning care with the support of the government being critical in promoting innovative practice and tackling risk factors on both local and national level. Innovative healthcare service is the result of knowledge intersection with new types of data, best practice and new emerging business models and forms of expansion capital. Investing in developing partnerships with other healthcare systems could mean investing in commercialising capability; Technologies developed in synergy constitute a powerful vehicle for commercialisation and out-licencing of intellectual property to the benefit of all participating parties. The notion of aggregating intellectual property and capital among providers creates a culture of innovation and purposefulness in the healthcare sector with a view to excellence and empowerment in healthcare service. It is a notion of empowering actors, employees and stakeholders and fostering alliances between venture investors, companies, and entrepreneurs, working
towards scaling individual solutions and successful innovation. On top of that, the convergence of the players in the sector will provide the means for healthcare spending and budgetary control as well as the necessary surveillance measures. Leveraging strong associations between various partners is expected to uncover investment opportunities over cross-industry boundaries and establish connections outside typical industry activity. Sustainable value added to business activity is equated with long-term benefits against healthcare cost, access, and quality. Access to new business channels for products and services will enable investors and innovators to exploit opportunities in developing and emerging markets. This can be an exciting opportunity for business and investment partners to gain access to new businesses, novel products, and services or improve existing ones.

The current healthcare structures across the OECD countries have demonstrated significant evidence of fragmentation of healthcare services, characterised by medical care institutions operating independently. The focus in these systems remains on disease management for individual patients rather than population health and wellness (Davies et al., 2009). Under this system, the split between general practitioners and specialists continues to subsist, with the hospital being the default setting for specialists and the community centre for general practitioners. At the same time, the involvement of multiple caregivers contributes to the system’s fragmentation and complexity. The pressure is felt when patients have to navigate their way through the system to seek healthcare. It becomes apparent that the need to remodel delivery methods from the perspective of the patient is paramount. Quality of care is compromised, as the lack of communication and coordination between care providers is limited and sometimes can be conflicting or confusing to the patient. For the above reasons the integration and coordination of delivery methods is necessary to bridge services and contributions from multiple social and healthcare providers. The key to overcoming integration challenges pertain to facilitating information flow within and between providers, supporting appropriate incentive structures for rewarding collaboration, and investing in financial models that can be a driving force towards system change and innovation.

Keeping close to users in the mental health sector is a novel way of building insights by making use of panels of users who will be working closely with healthcare professionals and other stakeholders. This has the advantage of getting an informed perspective from those
involved in care and treatment, whether it be patients or family members, who can articulate needs, which for the individual patient might be difficult or embarrassing to express. These panels could prove to be instrumental in uncovering varying cultural attitudes and concerns that hinder improvement in mental healthcare and thus help incorporate those elements into product design and development. It is in fact, a move towards mobilising knowledge and experience that was previously unexploited, harnessing the innovation potential of patients and their families and carers. This approach entails fundamentally a change in organisational culture. Campbell (1996) stressed the need to challenge the perceived status quo of the patients diagnosed with mental health problems and condemn the damage inflicted through outdated treatments. The core objective of such a change should be about fostering the circumstances for radical innovation by bringing all the key stakeholders into a kind of partnership. This involves acknowledging customers and other key influencers into planning and product design processes. Identifying users who could become competent board members is a vital part of this approach to innovation. The input of users could be used at the stage of formulating concepts to be tested where their responses could define real users’ needs to be incorporated into new concepts. At the stage of product development, their contributions could help in design improvements etc. The benefits are multifaceted for both users and the reputation of the company, but also the benefits for innovation opportunities are evident:

1. Identifying and prioritising the users’ needs.
2. Evaluating product development processes from the generation of ideas right through to their commercialisation.

Traditional decision-making structures need to change to be more inclusive of users. Barnes and Bowl (2001) underlined the concentrating power held by healthcare professionals who are reluctant to give part of it. Linnett (1999) suggested that this process involves essentially a change in the power balance in the organisation. Although the outcomes of user involvement in mental health have not been systematically assessed, there is a growing body of research on many different cases where the user involvement agenda has been implemented with various results. The Sainsbury Centre identified 318 user groups representing 9,000 users. The survivor workers market is experiencing a boom (Snow, 2002)
while the trend of involving mental health users in research is also growing (Rose et al., 1998; Faulkner, 2000). An example of innovative user involvement model is the Collaborative in Lambeth, which supports the formulation and commission of co-productive services with a primary focus on building capacity in primary care.

What is more, partnerships through joint ventures will facilitate the collaboration and partnership between different key players in the market with a view to offering individualised services. Setting clear outcomes over set periods with effective assessment mechanisms will provide service users with even more flexible, customised, and reciprocal services. Through ventures, opportunities to identify areas of under provision can arise where coordination of funds, knowledge, and expertise can generate added value for all parties involved. Such a case is the joint venture created by Care UK and Sussex Partnership NHS foundation trust where the South East coast was identified as an area of under provision for independent mental health hospitals in rehabilitation in the community. The increase in provider options can include various third sector agents and hybrids such as non-profit organisations, community providers, and educational institutions. The benefits of such partnerships are among others: identifying unmet needs occasioned by undifferentiated public provision, enhanced user involvement in service development and finally innovative approaches to service delivery (O’Brien et al., 2013; Shortus et al., 2013; Glasby et al., 2006). In this way, the public healthcare system can meet the demands in mental health provision while containing care costs, promoting localised engagement and accountability of multiple players without expanding private provision at the expense of social justice. This is a corporate and social vision that is compatible with today’s changing economic environment.

Factors in customer orientation affecting health service development

Healthcare services are probably the most important kind of services people use; thus, personalised attention is required. Health services need to be modified to individual patients, balancing their medical needs, to be efficient (Staniszewska et al., 2013; Berry and Mirabito, 2010). Furthermore, a study by Cohen et al. (2004) suggests that increased customer orientation seems to influence medical scientists’ working practices and their sense of professional expertise, while Ritchie’s analysis (1999) adds that evidence-based practice needs contributions from patients in a systematic approach that sets the basis for patient-
centred care. He also defined patient-focused care (p. 253) “as healthcare provided in a way that meets the particular needs of each individual seeking that care.”

In the past, healthcare organisations used to focus more on the expectations of their medical staff and third-party payers and less on their medical consumers’ needs (Alves et al., 2013; Ford and Fottler, 2000). However, in recent years, patients have increased their influence on the performance of healthcare organisations. They have become active participants in their healthcare experience, as they have easier access to information and know more about their alternatives. Today’s experience is more than medical procedures and clinical services. It is a holistic perception that starts before admission and is completed after discharge (Ford and Fottler, 2000). In addition, several environmental changes and increased competition among healthcare providers call for responsive services to patients’ wants and expectations. In consequence, executives must consider more effective and pleasant ways to provide healthcare services. For example, Wood et al. (2000) suggest that healthcare organisations should focus on new approaches, such as customer orientation, to achieve patient satisfaction. Additionally, a study by Ottenbacher and Harrington (2010) concludes that successful services need to be provided by highly skilled personnel (e.g. clinical and administrative staff), with good facilities both functional (e.g. the computer system) and aesthetic (e.g. the ambiance of the hospital). On the other hand, Tobin et al. (2002) explored the influence and efficiency of user involvement and discovered low levels of willingness and commitment from service users due to lack of motivation or invitation, stigma, and lack of information. They have stressed the importance of the background, mentioning (p. 93) that “the opportunities for consumer participation occur first at this clinical interface in terms of what information is transferred, in what direction, and in how the communication takes place. Nurturing participation at this level has a fundamental role in consumer empowerment.” Therefore, they proposed the development of a wide system that would integrate all kinds of activities, while Ford and Fottler (2000) add that this may be the only way for healthcare providers to deliver highly customised services.

As it is increasingly difficult in this highly competitive environment for healthcare organisations to gain and sustain a competitive advantage, they need to create a new value for patients, understanding better their needs and meeting both emotional and physical ones.
Duncan and Breslin (2009), however, argue that there is a limited understanding of those needs as well as lack of strategic orientation for exploring and exploiting that knowledge. Based on these issues, Ford and Fottler (2000) advised healthcare providers to move from the old paradigm to the new one. The old paradigm relied on medical staff and third party payers’ satisfaction, while the new one refers to patient-consumer’s experience, which is more than a clinical outcome. Therefore, Ford and Fottler (2000) developed a framework of ten strategic areas, suggesting healthcare organisations develop those organisational capabilities, which would allow them to improve their competitive positioning. Table 2.9 below shows the differences between the two paradigms on the ten strategic areas. Considering the analysis of the Greek mental health sector in Section 2.2.4, the importance and value of this outline becomes apparent.

Table 2.9 A comparison of the old paradigm (focus on physicians/third party payers) vs new paradigm (focus on the patient as customer)

<table>
<thead>
<tr>
<th>Strategic area</th>
<th>Old paradigm</th>
<th>New paradigm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer’s key drivers</td>
<td>Clinical effectiveness and cost efficiency</td>
<td>Patient-customer perceptions of quality and value</td>
</tr>
<tr>
<td>Patient-Customer co-production involvement</td>
<td>Limited involvement in coproduction</td>
<td>Maximum patient-customer coproduction of service experience</td>
</tr>
<tr>
<td>Culture</td>
<td>Provider-driven</td>
<td>Patient-customer driven</td>
</tr>
<tr>
<td>Staff selection and training</td>
<td>Focused primarily for technical proficiency</td>
<td>Focused on both clinical and patient customer service</td>
</tr>
<tr>
<td>Motivational strategies</td>
<td>Rewards primarily for technical proficiency</td>
<td>Rewards for both technical proficiency and customer service skills</td>
</tr>
<tr>
<td>Service system design</td>
<td>Design for technical efficiency and clinical effectiveness in department or function area</td>
<td>Design for seamless customer service across functional areas</td>
</tr>
<tr>
<td>Management of waits</td>
<td>Use customer waiting time to increase technical efficiency</td>
<td>Manage customer waiting time to enhance customer experience</td>
</tr>
<tr>
<td>Service environment design</td>
<td>Design for provider comfort and clinical efficiency</td>
<td>Design for patient-customer comfort and clinical efficiency</td>
</tr>
<tr>
<td>Measures of effectiveness</td>
<td>Costs, clinical processes, and medical outcomes</td>
<td>Costs, clinical processes, and medical outcomes plus the total service experience</td>
</tr>
<tr>
<td>Organisational improvement</td>
<td>Intermittent, reactive, and focused on medical issues</td>
<td>Continual, proactive, and focused on both medical, financial, and patient-customer satisfaction issues</td>
</tr>
</tbody>
</table>

(Source: Ford and Fottler, 2000)

Similarly, a study by Raju et al. (1995) reports that hospitals should gather and use information to reduce customers’ complaints; improve customer satisfaction and respond to customers’ needs. However, they differentiate customer satisfaction from ‘responsiveness to customers’.
The former refers to quality improvements and product modifications to keep patients happy, while latter relates to monitoring patients’ preferences and environmental changes. Considering the above, Gafni et al. (1998), who further explored and compared two treatment decision-making models - the physician as a perfect agent for the patient vs. informed treatment decision-making -, suggested three alternatives for the decision-making process for treatments. First, the clinician appears to be the ‘perfect agent’ for their patients, as they trust their doctor to choose the appropriate treatment, based on users’ preferences. Second is the ‘shared decision-making’ option (Gafni and Whelan, 1997), where the patient and doctor come to a decision together. Few patients would like to take the risk of making the treatment decision, but the majority feel like having a say (Tobin et al., 2002). A third option regards patients that come to a decision about the treatment, based on information shared by doctor. An important point in all cases is to encourage the physician to transfer the knowledge in a clear and non-biased way (Gafni et al., 1998). Other research, which was carried out by Ritchie (1999), examines how qualitative research can add to patient-centred care. It evaluates healthcare quality and highlights its two dimensions: the objective, which is the technical dimension originated from the evidence, and the subjective, which is the personal dimension as experienced by the service user. He argues that successful offerings come about when these aspects mutually complement each other.

Additionally, many studies underline that healthcare providers should identify and fulfil internal customers’ (employees) needs (e.g. Ordanini and Parasuraman, 2011; Umashankar et al., 2011; Bellou, 2010; Melton and Hartline, 2010; Bowen and Schneider, 1985). For example, Bowen and Schneider (1985) and more recently, Bellou (2010) agree that medical staff have an essential responsibility to deliver high quality care and please patients, as they are part of the service as viewed by the customer. Umashankar et al. (2011), who analysed the characteristics that influence internal innovation outcomes for customer service agents, back up this viewpoint, stating that internal innovation benefits user satisfaction. What is more, studies by Ordanini and Parasuraman (2011) and Umashankar et al. (2011) illustrate that service employees’ opinion throughout the design process advances innovation outcome and front-staff contribution. In particular, it operates as a forceful driver of service innovation volume and radicalness. It is noteworthy however, that Melton and Hartline (2010) take a differing view. They carried out an empirical study on customer and frontline employee
involvement in new service development and found (p. 411) that “frontline employees are less effective than previously thought as a source of new service ideas (and) firms should instead focus on incorporating those personnel in the full launch stage to effectively promote and deliver the new service”.

The secrets of success

The secret of success in such cases involves getting as close as it gets to the patients and focus carefully on their established behaviour patterns. This enables the creation of innovative services that significantly lower distribution costs while improving abiding to clinical protocols. Technology can extend access, increase standardisation, and drive labour productivity. The innovative models identified could be used to prove technologies in new ways, repurposing rather than reinventing. Successful innovations strictly link skills to the task, questioning existing practices. By doing so, entrepreneurs manage to decrease labour costs and at the same time eliminate all kind of constraints.

Another crucial point is to standardise all or most of the operating procedures wherever possible. The operating procedures of different kinds of effective innovations are always fully standardised, allowing the elimination of waste, the improvement of labour force and asset utilisation, and in general, the significant increase in clinical quality. Innovators always try to enhance their business models by utilising existing networks enabling them to reduce capital investment and operating costs. Many healthcare delivery models work with other sectors such as retail. This helps them to share costs, secure additional revenues, and in some cases to cross-subsidise.

2.4.4 Critical factors affecting innovation and corporate venture strategies in mental health sector

Corporate ventures can function as an effective funding mechanism for organisations in the mental health sector, generating cash from multiple sources and investing in entrepreneurial start-ups. They can also be of strategic importance: they can contribute to leveraging and upgrading core competencies while at the same time building an ecosystem (Henderson and Leleux, 2005). As the service economy grows into a networked collection of resources, competencies and activities, the value of coordinated networks within the same industry is
immerse. In a sector that is undeniably financially constrained, investments in technologies that could reduce costs and improve care are imperative. Interest has risen as a result in innovations that could provide more efficient and cost-effective care while at the same time generating sufficient financial returns. Through such mechanisms, such as flexible, long-term capital, including targeted grants, programme-related investments, social venture funds and endowments, all healthcare stakeholders could benefit from increased financial returns, mitigating risks and technological improvements.

Venture capital funds play a vital role in providing early-stage financing to small size start-up companies, and at a later stage of technology development, when investment becomes more attractive, a wider spectrum of larger companies are pulled in. This is an effective way to develop new ideas into healthcare products and services. For venturing decisions, unlike other strategic decisions, a different set of dimensions or specific conditions must be taken into account. One must pay attention to selection consequences, diversity on expectations, and the idiosyncratic nature of entrepreneurial opportunities and asymmetric distribution of knowledge about the entrepreneurial opportunity. The use of social networks for knowledge transfer and reduction of information asymmetry are determining elements of a successful venturing project (Venkataraman, 2002). By leveraging their industry and technology expertise, established firms in the healthcare sector can gain both direct financial benefits through superior selection of valuable ventures and indirect benefits through harnessing novel technology. Successful venturing in healthcare is not merely measured by revenue growth but also by the value added to the healthcare ecosystem. Strategic benefits may accrue to the investing firm even when the originating venture has dissolved providing that technology generated remains viable (Hoetker and Agarwal, 2007).

Allocating money to venture funds that have free reign presents the opportunity to find truly disruptive new business opportunities. Especially in the healthcare sector, incremental innovation is important to compensate for well-documented deficiencies and financial constraints. As healthcare seems to be entering a period of deflation, the pressure for reducing costs without having to compromise on quality of service provision is mounting. Opportunities for creative new start-ups can be an effective way for breaking away with obsolete structures and business models within the healthcare system. These new start-ups
are consumer oriented and aim to target the large healthcare organisations. Leveraging technology and other resources to the benefit of patients can be a real breakthrough in healthcare treatment. This could be a way of cutting down insurance and policy clutter while at the same time providing consistent treatment. The creation of innovative, independent and mostly small-sized business units can a most effective dimension of entrepreneurial orientation in a market where synergy, networking, and flexibility are vital in delivering systemic innovations in the shape of new products, services, technologies, or businesses. This can be more easily achieved than when a single person, team or business unit perform entrepreneurial activity.

Investing in corporate venture capital projects usually entails securing board seats, or at least board observation rights, which might provide access to knowledge of ventures’ key activities and technologies (Citron et al., 2009; Bottazzi et al., 2004). It could also mean a reduction in information asymmetries prior to acquisition (Benson and Ziedonis, 2005). An important component of financial performance is the possession of specialised knowledge and the ability to exploit information asymmetries. This stock of entrepreneurial knowledge may lead to other novel configurations of existing entrepreneurial knowledge and capabilities and thus generate significant innovation output (Dushnitsky and Lenox, 2005). From a corporate venture perspective, corporate entrepreneurship pursues an exploitation of resource potentials, activating latently existing and (in the course of time) accumulating specialist knowledge conducive to the specific conditions, resources and competences of the given market in which the venture functions. This kind of incremental learning contributes to significant innovation breakthroughs. However, such an endeavour could be compromised in case of internal organisational barriers, conflicts, and competition.

The intersection of various healthcare stakeholders, corporate, academic, governmental, and philanthropic partners could join forces in improving basic and applied research, deliver networks and resources for more timely and improved care, and could also contribute to the design of functional mechanisms to bridge the gap between knowledge and practice (Ennis and Wykes, 2013; Tambuyzer et al. 2014). Entrepreneurship effort could effect change on a scale that develops momentum and long-lasting power. From the corporate venture perspective various stakeholders participate in developing action and policy, achieve
cross-sectoral successful outcomes and sustainable progress. The economic crisis has boosted the emergence of new, innovative business entities, which aim to provide concrete, well-planned, and visionary business models as a response to the wasteful failure of traditional practices in the healthcare sector.

Factors and benefits affecting corporate venturing strategies and service innovation in Greek mental healthcare

The current situation in Greece calls for a reorganisation of the mental healthcare delivery system with particular emphasis being paid on flexible and innovative models that could benefit the public, especially in regions with limited socioeconomic resources. The joint venture approach in the mental health sector in Greece can provide such innovative and flexible solutions to long lasting problems in the sector regarding inadequate inpatient facilities, fragmented provision of services and inadequate policy planning, understaffed, and underfinanced mental health units. This approach could prove to be particularly beneficial at a time when Greece is facing a serious social, economic, and humanitarian crisis. People with mental health disorders are especially vulnerable and at risk at not being able to cope with problems such as poverty, unemployment, uncertainty and lack of social support.

Establishing integrated management services will improve outcomes for patients as well as access to a range of services. Under this model, patients, providers, and professionals can work together in the design of services that were previously largely unavailable, creating new corporate growth opportunities, and distinctive capabilities in the sector for the benefit of all parties involved. The capacity to innovate and share knowledge in not well developed, and there are few resources dedicated to these important activities in the mental healthcare sector in Greece. Innovation through corporate venture strategies will create knowledge-rich healthcare environments and will enable integrating knowledge use into practice. As we have already established, healthcare organisations can no longer operate on outdated blueprints. Organisations, jurisdictions, geographical boundaries, and public and private providers require collaborative relationships. The style of top-down, command and control management is no longer viable, which means that a radical change in the organisation and management philosophy in healthcare organisations is needed. This is true for the mental healthcare
settings as well, which although marked some remarkable progress in this respect, have still a long way towards achieving integrated innovation.

Further research is required to identify and assess effective innovations to support implementation efforts through the development of standards and appropriate criteria. Systematic research in the partnerships between government and healthcare organisations can help assess the pool of evaluation criteria, methods, and tools used in innovation activities. Innovation and integration of services means developing a consensus of care plan in full partnership with consumers and family members. Working together in developing knowledge about treatment planning is warrant to contribute to patient recovery and resilience, including integrated employment, participation in research projects, and provisions for career advancement. The involvement of service users in planning, development, delivery, and evaluation of mental health services is seen as a movement of service user empowerment and hallmark of enhanced quality. Research in local initiatives is expected to draw useful conclusions about the kinds of obstacles-material, organisational and cultural-to the possibility of users and user groups having a real influence on the shape of new consumer-oriented services. This way, suggestions can be made about how to manage transition towards restructuring organisational performance and implementing new policies under a user perspective. The contribution the present study aims to make is towards this direction: exploring the patterns of user involvement or representation at mental health hospitals in Northern Greece, the potential for innovation and leadership under a user perspective and the cultural obstacles that may hinder such efforts. A framework can then be developed which will analyse the stakeholder relation in mental health services and suggest changes in strategic, service and organisational planning following a user led approach to management innovation and entrepreneurship.

Nevertheless, in healthcare, not all desires and preferences can be fulfilled, as priorities have to be agreed. El-Guebaly et al.’s study (1983) was the first that noted that patient satisfaction is not always connected with treatment success. Even so, users of psychiatric services have taken a more active role in their treatment and hospitalisation over the recent years. Campbell (2001) noticed that until the early of 1980’s, patients used to be passive recipients of their treatment, having no participation. This is associated with Barnes
and Wistow’s (1994) study that reported that after the mid-1980’s, mental health patients begun to influence the services they use. This is similar to the conclusion of Lammers and Happell’s study (2003), which examines and debates the insights of mental health service users as regards their involvement in the development, delivery, and evaluation of mental health services. They found that the culture and methods by which mental health services are delivered have changed significantly over the years. These changes took place in response to worries about and condemnation of about the service quality that mental patients receive. The World Health Organization (1990) stated that patients should be involved in the decision-making process with regard to their treatment. It has been mentioned in the literature that mental health patients have not been treated with equal conscientiousness as other kinds of patients (e.g. Sperry et al., 2013; Kelly et al., 2012; Thompson et al., 2012).

Although there are still many stakeholders (e.g. doctors, nurses, hospital managers) who believe that service users have not much to contribute to decision-making on their care (Bennetts et al., 2011). Campbell (2001) describes how many conditions have changed in the last twenty years. Users have increased control over their care, over time, and now, there are more possibilities for consumers to be involved in the decision making process, though real involvement is still a work-in progress (Bennetts et al., 2011). There are special publications that inform patients about treatments and relatives or advocates are shown to benefit the effectiveness and the quality of patients’ involvement. For example, Victorian Mental Health Service (1999) reported that enhanced patient involvement had led to noteworthy and optimistic alterations at the stages of personal treatment, service planning, delivery, and assessment. It seems, therefore, that people diagnosed with mental illnesses can make valuable contributions to both mental health services and society.

Many studies support this viewpoint, with those by Tait and Lester (2005), Barnes and Wistow (1994), and Peck et al. (2002) providing detailed information about patient participation. First, Wistow and Barnes (1993) distinguished user involvement in two categories. The former seeks to create services that would be sensitive and responsive to the needs and requirements of users to enhance their quality, while the latter aims to empower users in decision making as regards the design, management, delivery, and review of services. Service providers, however, should make sure that user involvement would not be a stressful
experience and the patient should be supported by appropriate training and opportunities for preparation and debriefing (Barnes and Wistow, 1994). In addition, Tait and Lester (2005), who reviewed the mental health literature, list a number of gains and restrictions of user involvement in mental health services. Some of the most valuable benefits include: user involvement may increase the existing limited understanding of mental distress; develop alternative approaches to mental health and illness; be therapeutic and may encourage greater social inclusion. On the other hand, the lack of information, financial and time costs, concerns over representativeness and resistance to the idea of users, as experts appear to be the main barriers of patient involvement. Finally, Lord (1989), who carried out a research to appreciate the sources of understanding in participating in mental health services, concluded that the aims of involving patients are generally to advance health outcomes, raise satisfaction, and/or, reduce cost.

2.5 Summary of chapter

Many studies conclude that innovation is essential to generate long-term stability, growth, shareholder returns, sustainable performance, maximisation of employee happiness, and a continuing position at the leading edge of the industry (e.g. Alegre et al., 2013; Adner and Kapoor, 2010; Håkansson and Waluszewski, 2014). The term service innovation has been used in the literature to describe both new or improved services as well as the process that generates new service products using new knowledge, processes, and technologies (Agarwal and Selen, 2011; Lerro et al., 2012). Innovation is categorised as radical or incremental. Radical innovation refers to innovation that produces revolutionary change in firms, markets and industries, which provide substantially higher customer benefits relative to current products in the industry. Incremental innovation refers to line changes or improvements in a firm’s existing product offerings that satisfy the needs of its current and potential customers (Norman and Verganti, 2014; Dunlap-Hinkler et al., 2010; Varadarajan, 2009). It is true firms should create incremental innovations to meet today’s market demands. However, for long-term survival they also need to implement radical innovation, to helps them to develop competitive advantages and improve their position in the market place (Bao et al., 2012; Galanakis, 2006). Therefore, firms should plan strategically for the implementation of their service innovation. Innovation strategy provides a clear direction for dealing with strategic
issues, such as selecting the markets to enter and the skills to develop (Lendel and Varmus, 2011; Nybakk et al., 2011; Igartua et al., 2010), and focuses the effort of the entire organisation on a common innovation goal (Oke et al., 2012). Oke (2007) observed that highly innovative service firms have an explicit service innovation strategy that guides the development of new services.

There are numerous of service innovation strategies defined in the literature. The most common typology distinguishes proactive from reactive strategies. Proactive innovation strategies pursue product innovations to obtain product leadership (Johnston and Bate, 2013; De Brentani et al., 2010), while reactive innovation strategies pursue product development as a protection against competing products of others (van der Panne et al., 2003). Nevertheless, most companies choose to pursue an innovation strategy that mixes the pure proactive and the pure reactive (Gilbert, 1994). Many studies conclude that successful new services also need a well-designed and carefully coordinated development process (e.g. Edvardsson et al., 2013; Cheng and Krumwiede, 2012). A service innovation process establishes a pathway for developing new services and refers to the parallel and sequential activities that must be adopted for the service to be produced (Agarwal and Selen, 2011; Smith et al., 2007). It has been clear in the literature that this enhances the likelihood of success and leads to high quality in service innovation for organisations, which adopt formal processes (Piller et al., 2010). The process of innovation includes much more than the generation of innovative ideas (Dooley and O’Sullivan, 2001). The ability of an organisation to develop new ideas into final services and effectively manage the innovation process depends on several factors, such as effective execution of the service innovation process, project management, team management, goal management, knowledge management, risk-taking policy, technological capabilities and the organisational structure of the firm (e.g. Belkahla and Triki, 2011; Galanakis, 2006; Tidd et al., 2005). However, firms that choose to have a formalised innovation process confront some major obstacles (Edvardsson et al., 1995, p. 33), such as: a general lack of information about specifications and goals, uncertainty about who the sponsor is, difficulties in dividing responsibilities and allocating resources for the projects, and lack of systematic reporting, documentation and feedback.
Many researchers acknowledge that the service innovation process consists of activities, actions, information flows, and evaluations that develop and prepare new services for the market (e.g. Menor and Roth, 2007; Bernstein and Singh, 2006). Much of the research in the development of new services has shown that the service innovation process involves the stages carried out from the moment an idea about a new service is generated, up to its launch in the market (Alam, 2006; Avlonitis et al., 2001). In most cases these processes are described as stage models, because they adopt a series of stages in sequence (Tang, 1998), namely idea generation and screening, business analysis and marketing strategy, concept and technical development, market testing, then commercialisation and post-launch analysis.

Corporate entrepreneurship, on the other hand, promotes entrepreneurial managerial behaviour within organisation that challenges bureaucracy and encourages innovation (Figure 2.1), and this has been recognised by many authors as an applicable method for organisational survival and corporate competitiveness (e.g. Javalgi et al., 2014; Bhardwaj et al., 2011; Dunlap-Hinkler et al., 2010). Similarly, Belousova and Gailly, (2013), and Barringer and Bluedorn (1999) argue that corporate entrepreneurship uses the fundamentals of management and can be applied to exploit opportunities, take risks and create value to both the firm and its customers (Grimaldi et al., 2012; Korsgaard et al., 2011). What is more, corporate entrepreneurship is a key means of increasing corporate success through the creation of new corporate ventures within or outside the organisation (Narayanan et al., 2008; Sharma and Crisman, 1999). Therefore, corporate entrepreneurship can take a number of forms, such as intrapreneurship, dispersed entrepreneurship, and corporate venturing. Likewise, Covin and Miles (1999) distinguish corporate entrepreneurship (Table 2.1) in organisational rejuvenation, strategic renewal, domain redefinition and sustained regeneration.

As part of corporate entrepreneurship, corporate venturing has become a core concept in the strategic planning of some organisations as a means for achieving long-term growth and competitive advantages (Battistini et al., 2013; Guerrero and Peña-Legazkue, 2013). Furthermore, it concerns investment in highly risk activities, frequently related to those of the parent organisation, which introduces new products or enter into new markets, establishing new companies (Lin and Lee, 2011; Narayanan et al., 2008). However, ideas for new businesses can generate either inside or outside the organisation. Firms usually harness
both internal and external sources to have access to information, technologies, innovation, business practices, and/or networking with other companies that can enhance growth and profitability (Titus et al., 2014; McGrath et al., 2012). Considering that corporations function in a very insecure, highly competitive and globalised environment, they need to create and sustain competitive advantages and be continuously innovative, adopting new processes, creating novel ideas and developing and launching successful new outcomes (Machado et al., 2014; Chang, 2011; Sirmon et al., 2011). Studies by Carbonell et al. (2012), and Gao and Chen (2010) underline that new service development activities are of vital importance, as they strengthen current business and provide new business ventures. Other studies report that effective new service development is also critical to business prosperity and becomes the field of competition for many service organisations (e.g. Gremyr et al., 2014; Edvardsson et al., 2013). In particular, service organisations should be innovative as they thus enhance the profitability of current offerings through cost reduction and sales growth. Innovativeness also improves the loyalty of existing customers while attracting new ones, and aids firms to expand their business, exploiting new opportunities that offer strategic development and better positioning through differentiation (Kreiser et al., 2013; Durmuşoğlu et al., 2011). Furthermore, it is important to mention that service development may be distinguished as radical or incremental. Many researchers have categorised service innovations (e.g. Norman and Verganti, 2014; Bao et al., 2012; De Burcharth and Ulhøi, 2011; Dunlap-Hinkler et al., 2010). A study carried out by Avlonitis et al. (2001) revealed six types of service innovativeness, namely: new to the market services; new to the company services; new delivery processes; service modifications; service line extensions; and service repositioning (Table 2.4). A key insight is that services have some particularities that affect their development, delivery, evaluation, and competitiveness; service products are intangible, inseparable, heterogeneous, and perishable.

Considering all that, new service development is a risky process; both practitioners and researchers have made efforts to identify those factors that increase the possibility of success (e.g. Kim and Meiren, 2010; Edgett, 1994). Generally, the product innovation literature has found that a common set of factors - environmental, organisational, strategic, and procedural - affect the performance of a new offering (e.g. Ceschin, 2013; Jin et al., 2010; Boso et al., 2010). Some authors strongly suggest that the employment of a ‘champion’ (an
appointed proponent) is a critical element for success (e.g. Ulrich, 2013; Cooper, 2001). On the other hand, others present a range of factors that strongly influence new product success (e.g. Sing Wong and Tong, 2012; Narver et al., 2004). Furthermore, new service development processes involve a series of steps or phases between the moment an idea is created and its commercialisation in the market place. Both new service development strategy and development processes are found to play a critical role in the performance of the new offering (Alam, 2006). Companies usually adopt formal development processes that lead to new product success, generating as many good ideas as possible, then screening and analysing these ideas to reduce their number, advance the most profitable, and generally include stages, pre-specified activities, and evaluation points (Durmuşoğlu et al., 2013; Cowell, 1988).

With regard to the health services industry, fewer researchers focused on health service marketing, developing models or frameworks for the service development process (e.g. Borg et al., 2009; Windrum and Garcia-Goni, 2008; Duncan and Breslin, 2009). Bowers (1987) was the first to make extensive research on a large number of hospitals based on the Booz et al.’s (1982) model of new product development. He found that hospitals do not use external inputs to new service development, so their services may not meet customers’ needs. He used those results to develop a normative market-driven model of new service development for hospitals (Figure 2.14). Then, Windrum and Garcia-Goni (2008) combined the characteristics approach of Saviotti and Metcalfe (1984) with the Gallouj and Weinstein (1997) competences framework to build a multi-agent framework that involves policy makers and service providers as well as firms and consumers (Figure 2.15). Finally, Duncan and Breslin (2009, p. 14) presented an innovative new health service development programme that was developed and adopted by the Mayo Clinic, consisting of a four-step human-centred process.

In addition, several studies emphasise that firms should make efforts and plans to apprehend customers’ needs, then realise those needs by developing specific products and services (e.g. Feng et al., 2012; Blocker et al., 2011). It is widely recognised that customer-oriented businesses heighten customer satisfaction and deliver better service quality (e.g. Hillebrand et al., 2011; Homburg et al., 2011). Nwankwo’s study (1995), and more recently, Tajeddini (2011) conclude that organisations should have a clear understanding of the customer orientation concept. Otherwise, they can be misled into ineffective plans and
cursory changes in organisational practice that could jeopardise the future of those organisations. In addition, Bitner et al.’s study (1997) reports that the level of customer involvement depends on the type of services. Likewise, other scholars recognise that the users of a service can take different roles, creating economic value for the organisations who promote customer orientation and exchange of resources to be innovative (e.g. Korschun et al., 2014; Lee et al., 2011). The review of the literature has provided a plethora of roles that service-customers can adopt (e.g. Witkowska and Lakstutiene, 2014; Tajeddiini, 2010; Kaulio, 1998). These are: customer as resource, co-producer, buyer, user, and product. The first two customer roles are upstream, and the next three are downstream of the value-creation process (Lundkvist and Yakhlef, 2004; Nambisan, 2002). Nevertheless, it has been clear in the management literature that many factors influence the customer-organisation interaction in order that this may be beneficial (e.g. Chen et al., 2014; Cheung and To, 2011). For example, Nambisan (2002) and Laage-Hellman and Lind (2012) argue that customers are an excellent source of innovation, when the maturity of the technology and the alignment of the product line with the current customer base are high, while this does not stand when both elements are low. What is more, Veryzer and de Mozota (2005) found that user-oriented design influences new product development (Figure 2.16). This benefits the firm, in developing highly customised superior products or services that lead to successful innovation.

Many researchers have also argued that the relationship that has been established between organisation and customer, and the quality that the customer receives, are the two major factors that govern the potential customer in making the purchase of the service (e.g. Lau, 2011; Sigala, 2012a). Furthermore, Svendsen et al. (2011), and Nambisan (2002) support that product users can also contribute to product testing and product support. Customers who participate in the product testing process provide the firm with valuable information about product’s effectiveness, usability and so on. Moreover, customers with experience in using a product or service can function as supporters sharing their knowledge with other users. However, several risks are highlighted in the literature (Lengnick-Hall, 1996). First, it is necessary to mention that changes might even be negative. Secondly, nothing can guarantee that the outcome will be successful, while products and services that are not used properly will not lead to differentiation in the user’s behaviour or state.
As regards healthcare services, Alves et al. (2013), Shortus et al. (2013), and Ford and Fottler (2000) found that healthcare organisations tend to focus more on the expectations of their medical staff and third-party payers and less on their medical consumers’ needs. However, patients have increased their influence on the performance of healthcare organisations. They have become active participants in their healthcare experience, as they have easier access to information and know more about their alternatives. Today’s experience is a holistic perception, initiated before admission, with closure after discharge (Ford and Fottler, 2000). Tambuyzer et al. (2014), and Wood et al.’s (2000) studies suggest that healthcare organisations should focus on new approaches, such as customer orientation, to achieve patient satisfaction. Organisations need to create a new value for patients, understanding better their needs, and meeting these, both emotional and physical. Based on these issues, Ford and Fottler (2000) proposed that healthcare providers move from the old paradigm to the new one. Similarly, O’Brien et al. (2013), and Raju et al. (1995) argue that hospitals should gather and use information to reduce customers’ complaints, improve customer satisfaction, and respond to customers’ needs.

Moreover, studies by Alam and Perry (2002), and more recently Borg et al. (2009), found that services involve customers in their production and delivery when there is interaction (information and/or effort) between service provider and user. For this reason, customer orientation plays an important role, particularly in service firms, because of heterogeneity, inseparability, intangibility, and perishability (Feng et al., 2012; Berthon et al., 2004). Although customers do not pay much attention to this interaction, service firms should define their product-market orientation and place customers in the thick of it, as many companies fail to meet their customers’ needs (Homburg et al., 2011). This develops a creative collaboration between a firm’s employees and customers, with feedback, suggestions, and new ideas that emerge during their interaction (Witkowska and Laksutie, 2014). Nwankwo (1995) also suggests that firms have to create a highly customer-oriented profile through the development of a value system (Figure 2.17) which would allow the entire organisation to become more responsive to the demands of the customers.

The following chapter discusses and analyses the context of the healthcare industry and market in Greece, presenting the structure, demand and provision, and characteristics of
healthcare services. The chapter focuses particularly on the mental healthcare sector of the industry.
CHAPTER 3
EXAMINING THE PRIVATE HEALTHCARE SECTOR IN GREECE

The introduction of the National Health System (NHS) in 1983 set the basis for the provision and distribution of both public and private health services in Greece. The objective of this chapter is to explore the Greek private health services market and more specifically, the sector of mental health, including addictions (substance abuse rehabilitation). The chapter also includes the general characteristics of the industry, the factors that affect the demand for private health services, and the supply of health services by private health groups. The size of the health services market and the company profiles of the case hospitals are presented. Finally, the prospects of the Greek healthcare industry are discussed.

3.1 A current profile of the healthcare industry in Greece

3.1.1 The structure of health services

The structure of the Greek healthcare system in the basic levels of healthcare is as follows (W.H.O., 1996) (Figure 3.1):

- **Primary Healthcare**: It is also called outpatient care and covers services concerning the prevention and diagnosis without requiring the patient to stay in hospital. This level of care is covered by:
  - Public health centres, hospital outpatient departments and insurance funds;
  - Doctors; professionals in their private surgeries;
  - Microbiological Laboratories;
  - Diagnostic Centres;
  - Private outpatient clinics.

- **Secondary and Tertiary Healthcare**: This refers to services for patients who are hospitalised in hospitals or clinics as offered by: a) 144 public hospitals of the NHS and outside the NHS (military, S.I.I.) and 196 private hospitals (Health Units Company data,
Emergency Medical Care: This is provided nationwide by the National Centre for Emergency Aid (Ambulance Service).

Psychiatric Care: Apart from the psychiatric hospitals in the public and private sectors, mental healthcare is also supported by the psychiatric departments of general hospitals and a network of outpatient and community structures in the public sector.

Table 3.1 shows the number of hospital beds per 1,000 habitants accounted for in the censuses 1991 and 2001 by geographic region. According to the figures in the table, some improvement is noted for the regions of Epirus, Thessaly, Thrace, Crete, and Central Greece.

Figure 3.1 Organisational chart of healthcare system (source: W.H.O., 1996)
### Table 3.1 Complement indicator of hospital beds (2001 & 2011)

<table>
<thead>
<tr>
<th>Region</th>
<th>2001</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aegean Islands</td>
<td>5.0</td>
<td>4.1</td>
</tr>
<tr>
<td>Greater Athens</td>
<td>7.0</td>
<td>6.1</td>
</tr>
<tr>
<td>Epirus</td>
<td>3.7</td>
<td>4.3</td>
</tr>
<tr>
<td>Thessaly</td>
<td>3.2</td>
<td>4.0</td>
</tr>
<tr>
<td>Thrace</td>
<td>2.5</td>
<td>2.8</td>
</tr>
<tr>
<td>Ionian Islands</td>
<td>4.9</td>
<td>4.5</td>
</tr>
<tr>
<td>Crete</td>
<td>4.8</td>
<td>5.0</td>
</tr>
<tr>
<td>Macedonia</td>
<td>5.1</td>
<td>5.0</td>
</tr>
<tr>
<td>Peloponnese</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Central Greece</td>
<td>1.9</td>
<td>2.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5.0</strong></td>
<td><strong>4.8</strong></td>
</tr>
</tbody>
</table>

Number of beds per 1000 habitants

Source: Hospitals, N.S.S.G.

### 3.1.2 General characteristics of the industry

According to the World Health Organisation (1996), the majority of private hospitals for secondary care operating in Greece are classified among those whose capacity is from 41 to 100 beds, and there are also private hospitals which offer from 100 to 300 beds. Depending on their size, private general hospitals are divided into the following categories:

- **Large multi-clinics**, which are located in Athens and Thessaloniki, and are few in number. These clinics exceed 300 beds and the majority of them are staffed by highly trained and skilled medical staff, deploying high-tech medical equipment. They maintain agreements with insurers and public insurance funds, and with most insurance companies in the private sector. These clinics cover a wide range of services, including prevention and diagnosis.

- **Medium-sized clinics**, which also usually maintain contracts with private insurance companies and the public funds.

- **Small clinics**, most of which cover the cost of hospitalisation of their patients (in whole or part) via contracts with various public insurance agencies.

- **Neuropsychiatric clinics**, which are a separate category, are sufficient in number and their revenues come entirely from internal patients, with a high average annual occupancy.
As for the geographical distribution of private clinics, the majority are around the region of Greater Athens, followed by the area of Thessaloniki. In recent years, there have been transformations in the private hospital sector, since small regional units have consolidated with larger ones. Furthermore, in some cases, large units in the industry became international by expanding their operations in foreign countries. An example is the Athens Medical Centre, which has expanded its activities in various countries of the Balkan area. The difficulty of the smaller units in responding to the rapid development of medical technology and also the high cost of construction and equipment for new treatment units are the two primary reasons for the strategic acquisitions - mergers – consolidation of the smaller firms. Another one factor that discourages entrepreneurial activities in the sector is the lack of governmental support for new ventures. Despite the incapacity of public hospitals and their inability to provide quality services of healthcare, the Greek governments have not established a legal framework that would support the development of private units. This fact could only be explained if one analyses the local culture, which follows the notion that healthcare is a public good and should be provided by the state. Some of the governments of the past 15 years have made efforts to establish a friendly framework for entrepreneurship in healthcare, but they confronted the disagreement of the public via protests and strikes in the state hospitals. Nevertheless, there are few cases in which the state collaborated with private investors to create new state-of-the-art hospitals in the form of public-private partnerships. Considering that the governments could not explore and exploit opportunities for innovation in healthcare due to intrinsic weaknesses, such as the characteristic slowness and inflexibility, the prospect of public-private partnerships seemed to be an efficient mechanism to move forward, surpassing obstacles to developing and providing quality health services. The idea behind public-private partnerships in healthcare is to create centres of medical care, minimising the operation costs, while providing high-quality, innovative services to the public. Through public-private partnerships projects, new jobs are created, leading to the reduction in the ratio of unemployment, which is, especially now, an important shortcoming in the growth of the Greek economy. In the case of Greece, the governments are interested in attracting foreign capital inflows, as a way to escape from the vicious circle of continuous recession, boosting productivity, and hence, achieving growth.
Before attempting a detailed analysis of cases of public-private partnerships in Greece, it would be worthy to mention one peculiarity in Greek healthcare reality, characterized as ‘the Greek paradox.’ The ‘Greek paradox’ refers to the area of health and largely explains why the public-private partnerships model took so long to implement in Greece. Moreover, it may help us conclude that the public-private partnerships applied in Greece may be much different to the public-private partnerships initiatives of other countries. The ‘Greek paradox’ describes a peculiar situation in the Greek healthcare system, which is evidently the most privatized one between European countries while the total population is supposedly covered by the social security system. McKee et al. (2006) record in their study dozens of design problems and defects of the new public-private partnerships hospitals in Greece and the UK. These project where the private investor assumes the construction risk (construction delays, cost overrun) and operational risk of the support services within the new hospital. The transfer of risk presupposes proportionate penalties in case of breach of contract agreements, penalties that are never effective, however. In the event of failure or bankruptcy of a public-private partnership project, it is the state that is called to rescue and carry out the rest of the work. The involvement of the private sector in the construction of new hospitals may trigger favourable conditions for the emergence of corruption. The lack of transparency in the public-private partnerships agreement under the veil of ‘commercial confidentiality’, the movement of large sums of public money, the existence of financial consultants working simultaneously or sequentially in the public and private sector, are some of the factors creating favourable conditions for the emergence of corruption (Moschuris and Kondylis, 2006).

In the Greek economy, forging long and lasting agreements may be a challenge even for small-scale projects. In the case of public-private partnerships in the healthcare sector, assigning public responsibility to private investors may be considered as conferring responsibility for a practice thought of as inherently social and universal to profit making entities at the expense of public good (Siskou et al., 2009). The reasons that have affected the development of public-private partnerships in the Greek healthcare sector are described here below. Public-private partnerships should regularly be checked and by the standards of OECD and EUROSTAT to ensure the reliability and transparency of resource management and financing of such projects. It is not possible to evaluate the effectiveness of any public-private partnerships initiatives in hospital settings without reliable data and assessment
methodologies. It is clear that the deterioration of any socio-economic indicators in the healthcare sector - for example, the quality of services, equal access of citizens and general health indicators of the population -, can have a significant impact on the key features of the NHS. When assessing a public-private partnership investment, it is necessary to take into account both the financial and social dimensions of the project. If the above conditions are not met, the massive recourse to public-private partnerships for the development of public healthcare services (and improving the infrastructure of the NHS) is likely to result in the negation of their public nature while increasing the private sector involvement alone cannot guarantee a substantial progress in socio-economic terms. There is the obvious risk that healthcare is transformed from a public right into a commodity.

3.1.3 Synopsis of the mental healthcare system in Greece

Traditionally, the mental healthcare system of Greece constituted of a network of state psychiatric hospitals where patients were institutionalised. The development of this system occurred during the 19th and the 20th century when "asylum" units were established. In 1832, Greece had no specialised care units for mentally ill people, who received only informal treatment from their families or the church (Ploumpidis, 1989). The first mental healthcare institutions were founded on Corfu by the British, who handed the island over to Greece in 1864. Corfu’s hospital initiated biomedical psychiatry and was the paradigm for future infirmaries (Blue, 1993). The Dromokaition was established in Greater Athens in 1887 while a network of mental institutions were developed in Crete, Thessaloniki, and Athens at the beginning of the 20th century. At the end of the Greek Civil War (1946 – 1949), five psychiatric institutions composed the central part of Greece’s inpatient mental healthcare. By the late 1950s, the rise of private clinics and facilities was noted in Athens, Thessaloniki, and other large regional cities (Ploumpidis, 1989). Nevertheless, as Blue (1993, p. 306, 308) states, “the Greek government has reinforced the prominence of the large mental hospital in the Greek psychiatric care system through limited financial support for services, the absence of a national mental health policy, and psychiatric legislation and (...) it has been minimally involved at economic and policy levels in the creation of psychiatric care services other than mental hospitals”. This is in conformity with Madianos et al. (1999b, p. 170), who note that “centralization of psychiatric care with an absence of community mental health services and
of psychiatric beds in general hospitals; (2) uneven regional distribution of services in the country, leaving some regions without access to psychiatric care, and (3) inefficient management of resources and lack of qualified administrative staff (…) was totally inadequate to meet the psychiatric morbidity needs of the population”.

Despite the lack of detailed and accurate data about the mental healthcare use in Greece, it is known that the Greek mental health transformation was initiated in 1984 using funds from the European Community (Stefanis et al., 1986). That reform included the development of new structures, such as mental health prevention services at community level and psychiatric departments in general hospitals; the reduction of resident psychiatric patients through the development of alternative modes of care, and the improvement of service quality and living conditions through the training of mental health personnel (Madianos et al., 1999b). At the same time, most mental patients start their treatment in a private setting. Estimates show that more than 80% of those hospitalised in a state hospital had formerly been in a private clinic (Blue, 1993). Furthermore, Greek psychiatry has not assisted in the development of proper treatment and settings over time as it mirrored, until recently, the notion that institutionalisation is the appropriate handling for the ill. However, there were some efforts in the past, by Greek governments with the cooperation of experienced academics, to introduce new methods to enhance service quality and delivery. A day hospital was launched in Athens with a 24-hour emergency system (Mantonakis, 1981), two community mental-health centres were established, in Athens and in Thessaloniki (Madianos, 1983; Manos and Logothetis, 1983); psychiatric departments in general hospitals were developed across the country, and long- and short-stay homes have been set up to assist in deinstitutionalization (Blue, 1993).

More recently, a national programme, named ‘Psychargos’, was initiated by the Greek government to improve the quality and specialisation of services provided to patients (Madianos et al., 1999a). The first phase of the programme was executed in 2000 – 2001, where each prefecture of the country houses a psychiatric facility, with Athens and Thessaloniki having more than one (Bellali and Kalafati, 2006). More specifically, this phase should introduce new organisations for community-based care, such as half-way houses; nursing homes and outpatient units; upgrading of public hospitals’ facilities; operation of novel intervention and community after-care schemes, such as vocational workshops to train
patients; and training programmes in psychosocial rehabilitation for mental health personnel (Grove et al. 2002). The second phase of this programme has been running since 2002 until today and includes more initiatives, including:

- Integrated psychiatric and paediatric psychiatry clinics in general hospitals, including short-term inpatient units and a crisis intervention centre;
- Day care centres for adults, adolescents, and children;
- Customised psychiatric services to the target group;
- Ambulatory mental health units in areas with particular problems of access such as islands and mountainous regions;
- Mental health community centres for adults and child guidance centres for children and adolescents;
- Counselling services to meet the needs of families caring for the mentally ill (Efthimiou et al., 2013; Grove et al. 2002).

**Psychiatric Reform’ in Greece**

‘Unfulfilled reform,’ ‘incomplete effort,’ ‘neglected priority’ are some of the characterisations attributed to or associated with Greek psychiatric reform, which has already been in progress for two decades, but has not matched the hopes of those who believed in a change in how to tackle mental health problems. Even the question of funding, despite its undoubted importance, is only one side of a multifaceted problem, the solution of which requires serious administrative and institutional interventions. From an evaluation of progress so far, it can safely be said that psychiatric reform has not been established in Greece and has not eliminated the asymmetries and inequalities in the provision of mental health (Vandoros et al., 2013; Giotakos et al., 2010; Sakellis, 2009). Although it should not be overlooked that progress has been made (such as structures in the community, transformation of psychiatric hospitals), the following issues remain in the provision of public mental healthcare:

- a system of service quality assessment on the part of public entities and private legal entities, profit and non-profit,
- the connection of the funding of the mental health structures with the findings of the evaluation,
• updating public policy on Mental Health to delineate the objectives of the state and the actions of bodies,
• updating and completing the legal framework, taking into account the White Paper of the European Union and the perceptions of both the World Health Organization and the World Association for Psychosocial Rehabilitation,
• a decisive role for the Sectoral Committees of Mental Health, maintaining their operation and promoting service networking in each area,
• staffing of all bodies and
• consistent and adequate funding for all actions to ensure continuity of care.

Furthermore, the following issues were revealed from the interactions and the positions developed in a conference entitled ‘The child with mental health problems: The right to psychosocial rehabilitation,’ organised by the Greek Ombudsman (5th February 2009):

• lack of facilities for young people in need of urgent treatment (child and adolescent psychiatry),
• lack of structures for psychosocial rehabilitation of children and adolescents with mental health disorders or other serious problems that require medical rehabilitation,
• serious malfunction of private non-profit bodies and delays due to reductions in funding.

Resolving these issues is crucial to improving the quality of care for people with mental health problems and to provide greater protection of their rights. However, no policy on mental health can be successful if not accompanied by measures that combat the stigma of mental illness and social prejudices. At the same time, it is necessary to develop a support system for those families that have a mentally ill member (Triantafyllou and Angeletopoulou, 2011; Stylianidis, 2009). Psychiatric reform regards safeguarding the rights of people with mental health issues and the role this can play both as a philosophy for the modernisation of services that are focused on the asylum, and as a model for launching relevant procedures across the Balkan region (Henderson, 2009). Although the value of psychiatric reform is recognised, its evolution so far has proven incomplete. This conclusion emerged from the conference ‘Psychiatric Reform in Greece: Requirements, recommendations and solutions’, organised by the Greek Ombudsman in March 2009 (Sakellis, 2009). It was also highlighted that:
1) Psychiatric reform is not well established in Greece. It was emphasised at the conference that there lacks a movement that would focus on the cooperation of workers in mental healthcare with patients and their families. It is worth noting that individual initiatives cover the absence of a comprehensive state response to institutional shortcomings and problems.

2) Current progress in mental health reform was rated as ‘perverse’ because:
   i. the reduction of psychiatric beds combined with the lack of alternative community services resulted in dozens of makeshift beds in psychiatric hospitals and psychiatric clinics in general hospitals
   ii. it has not yet achieved the desired ideological and institutional change that will lead to the disappearance of the concept and practice of detention and other restrictive methods,
   iii. the power relations with patients have not been reshaped in such a way as to transform them into subjects of change,
   iv. the rationale and practice of the inpatient bed, either for housing or treatment, continues to dominate at the expense of support and alternatives to ‘the asylum’.

3) The absence of thorough and precise planning and the lack of guidelines on the main issues were identified in official mental health policy. Also, the parallel existence of the immunity system and care services in the community is regarded as problematic, while the lack of prevention, the inadequate accessibility to health services and the poor quality of care were reported as ‘chasms in mental health.’

4) The issue of ‘segmenting’ mental health services is regarded as important. Both the primary network of outpatient services with inpatient units and the inadequate horizontal communication between the outpatient services cause major difficulties.

5) Mental health of children and adolescents is assessed as a neglected priority. In particular, many in the conference noted that:
   i. research funding is inadequate in Child Psychiatry, and this is not a subject in education,
   ii. there is a shortfall in relevant structures for mental healthcare in Greece. Overall, from the 400 units that were provided under the scheme ‘Psychargos’, only ten
are for children and adolescents. What is more, the 65 mental health facilities for children and adolescents set up in the last 25 years are unevenly distributed and so do not provide coverage for the entire country,

iii. the existing structures are understaffed or barely functioning due to limited funding. There is also a shortage of hospital inpatient units (40 beds in Athens and Thessaloniki) while there is a lagging behind in developing new structures as well as structures for day care (e.g. for young people with autism),

iv. there are no organised and well-coordinated prevention programmes.

It must be understood that every action that delays Psychiatric Reform does not harm simply the mentally ill and their families, but works against the entire project of reform in the area of social solidarity and acts against the people, social action, and the richness of diversity in social aggregation (P. Giannoulatos, personal communication, March 9, 2011).

3.2 Innovation and organisation of private healthcare services in Greece

The main factors affecting the demand for the services concerned, listed in the following sections of the chapter, presents some results from the Household Budget Report by N.S.S.G., in an attempt to outline some characteristics of the demand. Following the discussion on demand, data are presented regarding the industry’s supply side, describing the structure of private health services in Greece.

3.2.1 Factors affecting the innovation activity

The most important factors affecting the demand for private health services (primary and secondary) may be summarised as follows:

- Demographic and social factors (age, living conditions, place of residence - access to public health services).
- Economic factors (income, prices of services, level of insurance).
- The level of public hospital services. Any deficiencies in the structure, organization and operation of public hospitals (hours waiting in outpatient departments, hospital
conditions, accommodation infrastructure, adequate medical and nursing staff), often turn the public to health services offered by the private sector.

- The bureaucratic barriers and the long queues seen during the procedures of registration and implementation of major tests and diagnostic services provided by public funds to their members meant that many patients turned to the private sector.
- Technology is a major factor since the advanced technology in medical equipment increases the rate of positive results in diagnosis and treatment.

In recent years the investments from the private sector in out-patient care and high diagnostic technology are significant, making the provision of many services faster, easier and more importantly, more valid and reliable. Also, the absence of certain public hospitals - particularly in the provinces - of high-tech diagnostic and medical equipment, building infrastructure and beds and medical/nursing staff, often operate in favour of primary and secondary care in the private sector.

3.2.2 Characteristics of demand

Table 3.2 shows the evolution of the average monthly household health expenditure according to the results of the two recent Household Budget Reports of N.S.S.G. (1998/99 and 2004/05). As seen from this table, the amount of this expenditure between the two periods shows an increase of 35.9%, while the share of the health expenditure in total average monthly outgoings of households increased from 6.82% to 7.15%.

<table>
<thead>
<tr>
<th></th>
<th>2004/2005</th>
<th>2011/2012</th>
<th>Rate of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total expenditure</td>
<td>1,383.24</td>
<td>1,792.28</td>
<td>29.6%</td>
</tr>
<tr>
<td>Health expenditure</td>
<td>94.29</td>
<td>128.17</td>
<td>35.9%</td>
</tr>
<tr>
<td>Share in €</td>
<td>6.82%</td>
<td>7.15%</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Household Budget Reports, N.S.S.G.

The last Household Budget Report was conducted by the N.S.S.G. during the period February 2013 - January 2014, on a sample of 6,555 households and 17,386 members across the country, to collect detailed information on the value of purchases and earnings of households.
as well as the demographic and social characteristics of these and their homes. Some of the results of that research are presented below in Table 3.3 and Figure 3.2 below.

Table 3.3 Average of household’s monthly expenditure on health by category of region (2011/12)

<table>
<thead>
<tr>
<th>Characteristics of Households</th>
<th>All regions</th>
<th>Urban Regions</th>
<th>Semi-urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Urban</td>
<td>Greater Athens</td>
<td>Thessaloniki</td>
</tr>
<tr>
<td>Total purchases</td>
<td>1,792.28</td>
<td>1,940.59</td>
<td>2,013.20</td>
<td>1,979.47</td>
</tr>
<tr>
<td>Health expenditure</td>
<td>128.17</td>
<td>134.71</td>
<td>138.84</td>
<td>132.77</td>
</tr>
<tr>
<td>Pharmaceutical products</td>
<td>21.05</td>
<td>19.72</td>
<td>20.47</td>
<td>17.82</td>
</tr>
<tr>
<td>Other medical products</td>
<td>1.42</td>
<td>1.32</td>
<td>1.12</td>
<td>1.63</td>
</tr>
<tr>
<td>Therapeutic appliances and equipment</td>
<td>3.07</td>
<td>3.21</td>
<td>2.78</td>
<td>4.44</td>
</tr>
<tr>
<td>Medical services</td>
<td>29.85</td>
<td>30.78</td>
<td>32.75</td>
<td>33.62</td>
</tr>
<tr>
<td>Dental services</td>
<td>39.91</td>
<td>44.29</td>
<td>44.87</td>
<td>45.51</td>
</tr>
<tr>
<td>Services of microbiological laboratories and radiological centres</td>
<td>9.59</td>
<td>10.41</td>
<td>11.63</td>
<td>9.40</td>
</tr>
<tr>
<td>Services of paramedic personnel</td>
<td>4.32</td>
<td>4.71</td>
<td>4.21</td>
<td>6.15</td>
</tr>
<tr>
<td>Other not hospital services</td>
<td>0.52</td>
<td>0.49</td>
<td>0.56</td>
<td>0.64</td>
</tr>
<tr>
<td>Government owned hospital care</td>
<td>5.19</td>
<td>5.09</td>
<td>5.38</td>
<td>4.27</td>
</tr>
<tr>
<td>Private hospital care</td>
<td>13.25</td>
<td>14.70</td>
<td>15.08</td>
<td>9.29</td>
</tr>
<tr>
<td>Health expenditure share on total purchases (%)</td>
<td>7.15</td>
<td>6.94</td>
<td>6.90</td>
<td>6.71</td>
</tr>
</tbody>
</table>

In €

Source: Household Budget Reports, N.S.S.G.
According to the data of this survey, the average monthly total health expenditure per household around the country, for the particular period, amounted to €128.17 representing 7.15% of the total monthly outgoings per household. As shown in Table 2.5 the highest ratio of health expenditure to total purchases corresponds to households in rural areas (8.28%) and the lowest to households in the region of the capital (6.9%), while in absolute terms, the households living in the capital have the highest average monthly cost (€138.84). In addition, for all types of areas, the largest item of health expenditure is on dental services, followed by spending on medical services in general. Spending on medicines and hospital care is comparatively lower. Finally, Table 3.4 shows the domestic private consumption of health services at constant prices during the previous years, according to the World Health Organisation/Europe. As is demonstrated by the preliminary data in the table, domestic private consumption on private health was at much higher levels (2011: €8.5 million) than the expenditure of households on public health (2012: €4.3 million). The average annual rate of change in household expenditure on private health rose, over the specific period, to 17.9%, while the average annual rate of change in expenditure on public health (9.8%) fluctuated at lower levels.
Table 3.4 Domestic consumption of health services in constant prices (2008 - 2012)

<table>
<thead>
<tr>
<th>Category</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Households expenditure on public health</td>
<td>2,930</td>
<td>3,964</td>
<td>4,252</td>
<td>4,495</td>
<td>4,265</td>
</tr>
<tr>
<td>Households expenditure on private health</td>
<td>4,399</td>
<td>4,857</td>
<td>6,962</td>
<td>7,696</td>
<td>8,501</td>
</tr>
</tbody>
</table>

in € million.

Source: European health for all database (HFA-DB), W.H.O./Europe

3.2.3 Organisation and structure of the industry

The introduction of the National Health System (NHS) in 1983 marked the beginning of the large structural changes in the availability and distribution of health services in the country. The investments made in health for several years after 1983 were aimed at mitigating one of the major chronic structural problems of the Greek public health system, namely the existence of significant regional disparities in the delivery of health services, to the particular detriment of the rural population. These investments concern the following (W.H.O., 1996):

- the creation of a Pan-Hellenic network service in primary healthcare in rural areas, to meet the needs of residents and the increased needs presented during the tourist season,
- the upgrading of the infrastructure of the secondary and tertiary medical units,
- the construction and operation of three Regional University Hospitals (Ioannina, Patras, Heraklion),
- the implementation of the «reformation» programme of mental health services through the replacement of the institutional system by a network of preventive and curative outpatient structures,
- the improvement of the functioning of hospitals by upgrading their infrastructure and through the renewal and completion of medical equipment and patient accommodation.

Over the past decade, private health services have had a significant growth advantage through their rapid adaptation to technological developments. Today, a large proportion of outpatient care in Greece (mental health services included) is covered by the private sector.
The capacity of the Greek hospitals

According to the figures in Table 3.5, which derive from the data of N.S.S.G., in 2012, 313 hospitals throughout the country operated with 53,888 beds in total (172 beds per hospitals on average), 37,574 of those beds (share 69.7%) corresponding to 140 public hospitals and 14,707 beds (27.3% share) to 167 private clinics, while 1,607 beds are also registered in 6 clinics that serve as Legal Entities under Private Law (L.E.P.L.) (Figure 3.3).

Table 3.5 Hospitals by legal form of ownership (2001 - 2012)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Number of Hospitals</th>
<th>Total number of beds</th>
<th>Number of beds in public hospitals</th>
<th>Number of beds in private hospitals</th>
<th>Legal Entities under Private Law</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>356</td>
<td>52,586</td>
<td>37,016</td>
<td>15,286</td>
<td>284</td>
</tr>
<tr>
<td>2002</td>
<td>350</td>
<td>52,474</td>
<td>37,047</td>
<td>15,134</td>
<td>293</td>
</tr>
<tr>
<td>2003</td>
<td>341</td>
<td>52,495</td>
<td>37,457</td>
<td>14,745</td>
<td>293</td>
</tr>
<tr>
<td>2004</td>
<td>339</td>
<td>51,404</td>
<td>36,438</td>
<td>14,673</td>
<td>293</td>
</tr>
<tr>
<td>2005</td>
<td>337</td>
<td>51,500</td>
<td>35,730</td>
<td>15,141</td>
<td>629</td>
</tr>
<tr>
<td>2006</td>
<td>336</td>
<td>52,276</td>
<td>36,186</td>
<td>15,038</td>
<td>1052</td>
</tr>
<tr>
<td>2007</td>
<td>326</td>
<td>51,781</td>
<td>36,142</td>
<td>14,460</td>
<td>1179</td>
</tr>
<tr>
<td>2008</td>
<td>327</td>
<td>51,762</td>
<td>35,814</td>
<td>14,528</td>
<td>1420</td>
</tr>
<tr>
<td>2009</td>
<td>319</td>
<td>51,871</td>
<td>35,808</td>
<td>14,515</td>
<td>1548</td>
</tr>
<tr>
<td>2010</td>
<td>317</td>
<td>52,511</td>
<td>36,554</td>
<td>14,389</td>
<td>1,568</td>
</tr>
<tr>
<td>2011</td>
<td>317</td>
<td>53,701</td>
<td>37,053</td>
<td>15,082</td>
<td>1,566</td>
</tr>
<tr>
<td>2012</td>
<td>313</td>
<td>53,888</td>
<td>37,574</td>
<td>14,707</td>
<td>1,607</td>
</tr>
</tbody>
</table>

Source: Hospitals, N.S.S.G.
Table 3.6 and Figure 3.4 illustrate the hospitals by legal form of ownership and geographical region.

**Table 3.6 Hospitals by legal form of ownership and geographical region (2012)**

<table>
<thead>
<tr>
<th>Geographical region/Hospital category</th>
<th>Total*</th>
<th>Public sector</th>
<th>Legal Entities of Private Law (L.E.P.L.)</th>
<th>Private sector</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospitals</td>
<td>Beds</td>
<td>Hospitals</td>
<td>Beds</td>
</tr>
<tr>
<td>Total</td>
<td>313</td>
<td>53,888</td>
<td>140</td>
<td>37,574</td>
</tr>
<tr>
<td>Greater Athens</td>
<td>103</td>
<td>22,652</td>
<td>41</td>
<td>14,824</td>
</tr>
<tr>
<td>Central Greece &amp; Euboea</td>
<td>25</td>
<td>2,385</td>
<td>13</td>
<td>1,820</td>
</tr>
<tr>
<td>Peloponnese</td>
<td>29</td>
<td>3,663</td>
<td>18</td>
<td>3,336</td>
</tr>
<tr>
<td>Ionian Islands</td>
<td>7</td>
<td>1,098</td>
<td>6</td>
<td>1,048</td>
</tr>
<tr>
<td>Epirus</td>
<td>7</td>
<td>1,634</td>
<td>5</td>
<td>1,604</td>
</tr>
<tr>
<td>Thessaly</td>
<td>35</td>
<td>3,808</td>
<td>5</td>
<td>1,830</td>
</tr>
<tr>
<td>Macedonia</td>
<td>67</td>
<td>12,508</td>
<td>28</td>
<td>7,698</td>
</tr>
<tr>
<td>Thrace</td>
<td>6</td>
<td>1,215</td>
<td>4</td>
<td>1,168</td>
</tr>
<tr>
<td>Aegean Islands</td>
<td>16</td>
<td>2,102</td>
<td>11</td>
<td>1,900</td>
</tr>
<tr>
<td>Crete</td>
<td>18</td>
<td>2,823</td>
<td>9</td>
<td>2,346</td>
</tr>
</tbody>
</table>

* Excluding military hospitals and beds therein.

Source: Hospitals, N.S.S.G.
Figure 3.4 Map of Greece
3.3 Profiles of case hospitals

This section illustrates the profiles of the five case hospitals, located in the Northern part of Greece.

*Thermaikos Hospital*

Built in 1974, Thermaikos is a fully licensed and accredited 150-bed hospital, one of the largest private psychiatric units in Thessaloniki area. A new expansion investment took place in 2008 to accommodate the needs of a sophisticated and multidimensional mental health unit. The building complex of Thermaikos Hospital consists of two buildings, functionally linked with a connecting corridor. The two premises are divided into four nursing units that have the greatest possible autonomy without any particular classification of patients into specific categories. The hospital offers rooms with en suite sanitary facilities and personal wardrobes, specially designed indoor and outdoor areas for recreation, dining rooms, occupational therapy rooms, library and multimedia facilities, medical labs, a conference centre, and suitable infrastructure for people with disabilities. Within the operational framework of the hospital and along with pharmaceutical-biological treatment of mental illness and the individual psychotherapeutic interventions for selected patients, various groups of activities are carried out. These vary depending on their purpose and composition. Their general context is based on the principles of a therapeutic community: respect for human dignity and reduction of stigma. This approach leads to psychotherapy groups, expression groups (occupational therapy) and recreational activity groups such as music, board games, and so forth. Moreover, healthcare is offered to patients from the perspective of an interdisciplinary approach, aiming at comprehensive patient care. Physicians, nurses, psychologists, social workers and occupational therapists are kept at the disposal of the patients and their relatives.

*Castalia Hospital*

Castalia Hospital is a new comprehensive psychiatric hospital committed to providing easy access to superior quality, cost-effective mental health services based in the heart of the Thessaly region, the city of Karditsa. The hospital provides 24-hour nursing care, psychiatric treatment and rehabilitation, regular input from a multi-disciplinary psychiatric team, with the patient under the day-to-day care of a psychiatric consultant. This 150-bed mental health
centre comprises independent nursing units, such as those for personality disorders, psychoses, neuroses, psycho-geriatrics, detoxification from dependencies. It also provides diagnostic and treatment services across the spectrum of mental disorders for adults, with the use of pharmacotherapy and psychotherapy (individual and group). Moreover, parallel therapeutic activities are applied (occupational therapy, exercise, speech therapy, etc.), rehabilitation services and reintegration programmes.

**Galini Hospital**

Galini Hospital was founded in 1967 in the area of Kavala with its primary purpose the treatment of mental disorders in the region of Eastern Macedonia and Thrace. At the beginning of its operation, Galini was able to provide inpatient care for 40 patients. The needs of the area for providing healthcare services to the mentally ill have increased, leading to the creation of new sites, more beds and new operating divisions. Today, Galini is a 170-bed multi-disorder hospital, providing specialist individually-tailored treatments and therapies for all mental health and emotional issues through inpatient, day care and outpatient services. The hospital specialises in intensive, acute inpatient treatment of patients with severe and complex diagnostic mental health presentations, applying modern therapeutic methods, which are designed to tackle mental illness and to enable and socialise patients. The holistic treatment of mental illness is carried out with the collaboration of the following clinics:

- **Psychiatric clinic**: diagnosis and treatment of mental disorders through medication and psychotherapy. As part of the psychiatric clinic, there operate an emergency treatment department; a psycho-geriatric department for patients with senile psychoses and cognitive disorders and an alcohol rehabilitation department,
- **Psychological services**: individual and group psychotherapy (supportive and consultative type); diagnostics with psychometric tests; psychosocial education of family members,
- **Naturopathy centre**: physical rehabilitation of patients,
- **Centre for occupational therapy and social reintegration**: occupational therapy provides therapeutic activity, often of a creative kind: groups include painting, art therapy, traditional and modern dance, discussion, and hygiene.
In 1997, a team of five distinguished doctors set high goals and standards, deciding to proceed with establishing a psychiatric hospital in the region of Drama in north-eastern Greece, where there was a total absence of a well equipped psychiatric institution. Saint Irene Hospital is committed to attaining and enhancing the leadership role in behavioural health, mental health, and psychiatric services. Saint Irene offers individualised levels of care in a tranquil and healing environment. The highly qualified multidisciplinary staff strives to provide the highest level of psychiatric care possible for every clientele (children, adolescents, adults, and the elderly) through a continuum of care that includes diagnostic evaluation, treatment, prevention, education, relapse prevention and aftercare. Saint Irene aims to provide services covering all aspects of mental health and psychiatry for outpatient services, inpatient care and day program, satisfying the growing needs of the public in terms of:

- Comprehensive information and education on mental healthcare
- Access to skilled and professional expertise
- Access to a modern, high quality and fully equipped treatment facility
- Friendly and individualized service
- Efficient and proven techniques for treatment
- Healing environment and setting

Saint Irene’s vision is to be a leader in mental healthcare by setting the highest standard of excellence through the staff’s commitment to service, compassion, ethics, and fair treatment for all, providing world-class services in mental health and psychiatric care, and therapeutic services through a team of highly qualified, skilled and caring professionals, integrating various aspects of the body and the mind for the well-being of each individual, contributing, at the same time, to the Greek mental health programme. The Special Clinics at Saint Irene provide a range of evaluative counselling and assessments including treatments for patients with psychiatric disorders, mental health problems and learning disorders in children, adolescents, and adults. The hospital’s doctors and paramedical staff work at both group and individual levels for inclusive high-quality medical care in an attempt for patients to spend creatively their spare time, developing social skills, and achieving personal satisfaction. The programmes aim to provide education, fun, rewarding, care, and guidance to patients, and
also to detect and identify psychopathological factors, which in collaboration with the attending psychiatrists will be addressed timely and efficiently. Complementary to the psychotherapeutic groups, psychologists plan, organise, and perform additional actions, such as excursions and educational trips, aiming to a quicker socialisation of the patients.

**Eleftheria Hospital**

The design of Eleftheria hospital has been conducted in such a way that the hospitalization space is clearly separated but acts cooperatively with the headquarters and additional areas. Visitors, suppliers or even the audience who wish to attend a speech at a special conference room do not meet with the hospitalized patients, thereby ensuring confidentiality. All areas of the hospital look onto the garden, which consists of twelve acres of greenery, of which seven are available for patients. A balcony and the garden area are offered for leisure and recreation. Alternatively, there is a bright entertainment area along with several other recreation areas and activities. In Eleftheria hospital, keys are not being used, and the hospital’s policy prevents the use of railings. The hospital provides utmost security on all levels, by applying the latest technological features, ensuring patients’ safety, and protection of personal data. Among the key operational goals of Eleftheria is the therapy, treatment, and long-term control of mental illness, applying the best possible means and ways. The brand new building infrastructures provide patients with comfortable rooms without railings and prominent restrictive measures, keeping patients away from conditions of pollution. There are open spaces and recreational fitness rooms, movie theatre, and occupational therapy rooms providing pleasant living conditions for the patients.

Eleftheria hospital is divided into three sections: psychiatric, psychogeriatric, and rehabilitation. The scientific staff of the hospital comprises two permanent psychiatrists with experience in the practice of psychiatry and specializations to new treatments and rehabilitation methods. Additionally, the hospital employs permanent psychologists who strengthen the medical force, helping with the establishment of therapeutic effects. Apart from the conventional treatments of mental illness, Eleftheria’s capabilities include group therapy, individual and family psychotherapy approach. The hospital also provides patients with the opportunity to follow outpatient treatments, visiting the doctor at regular intervals. In the Psychogeriatric wing of the hospital, the medical, nursing and support staff ensure the
safe, decent and pleasant stay of the older patients. Finally, innovative methods are being
applied to alcohol, smoking, and gambling addictions. The doctors work with the paramedic
staff to develop appropriate programmes and activities to help addicted patients to heal and
reintegrate into society. The group psychotherapy is integrated into the therapeutic
intervention, for both the hospitalised patients and outpatient care. Each patient is flanked by
both therapists (usually two psychologists), and other patients with similar issues and
illnesses. The opportunity provided to every patient to share their concerns, and interact with
other patients allow them to appreciate their health condition and gain confidence, which is
critical in overcoming those health issues.

3.4 Conclusion and prospects of private healthcare sector in Greece

In the private health services sector, providers operate large-size, and well-organised
companies with extensive experience, which in many cases, constitute powerful business
groups. In most cases, the physicians act as shareholders of companies beyond their capacity
to provide medical care, and participate actively in the management of the units. The failure
of the public sector to provide high-quality healthcare in combination with structural
problems of the Greek NHS (e.g. inadequate infrastructure, technological retardation, and lack
of medical - nursing personnel) are significant limitations of the healthcare industry in Greece.
The rise of living standards, the gradual aging of the population, the emergence of new
diseases, and the increasing number of people covered by private insurance companies
contribute to the progressive increase in demand for private health services and preventive
medicine. Moreover, the evolution of medical science along with the evolution of technology
in the healthcare sector, lead to a growing demand for direct, more efficient and quality
healthcare services. Particularly in recent years, the contribution of the Greek stock market
was important to the industry and combined with the high profitability of powerful business
groups helped in the implementation of major investment plans. Moreover, large firms as
members of international organisations maintain partnerships with major medical institutions
abroad thus ensuring their participation in various research projects. Finally, a strong point for
the industry is considered the "industrial peace" in the private sector as opposed to the public
where the strikes of the medical - nursing staff are common.
Furthermore, competition is particularly fierce in the sector of private healthcare services in Greece. The entry of a new business in the industry of private health services - from the technical and economic point of view -, is not an easy task. The obstacles to the establishment of new companies in the industry dominate in the current institutional framework. In the case of hospitals, the conditions of business creation, and especially the construction specifications, are considered as particularly severe by stakeholders. On the other hand, healthcare services targeted to individual consumers; hence their bargaining power is limited. However, the current economic situation in Greece, the opinion of the doctors combined with the decisions of the insurance companies lead patients to choose the most economically advantageous solution in the context of their needs and requirements. Finally, the foreign markets (particularly those of Eastern Europe and Turkey, which show significant deficiencies in health infrastructure) concentrate the interest of investors of large business groups. Another challenge lies in the geographic imbalance of private hospital units, creating growth opportunities beyond the major centres (i.e. Athens and Thessaloniki) of the country, in which is currently concentrated the operation of the private healthcare groups. This development is reinforced by the fact that there is considerable room for improvement in the quality of healthcare in other provinces. The extension of cooperation of private healthcare facilities with private insurance companies as well as the contracts with insurance funds has resulted in broadening their customer base through the coverage of medical expenses for a greater range of patients.

Moreover, the increasing number of migrants, the economic surface of which does not enable them to benefit from private healthcare services has led to congestion in public hospitals, an element that turns a part of demand towards the private sector. Also, the proliferation of programmes through interest-free instalment payment is a reality in the field of private healthcare, along with the “outpatient card,” which offers scalable discounts for doing series of medical tests. Finally, some additional reasons – such as home care, provision of day nursing services, telemedicine and robotic surgery, rehabilitation centres, nursing hostels and geriatric clinics, and stem cell banks -, have significant growth potential in Greece. Similarly, medical specialisations and units – such as paediatric, gynaecological oncology, cosmetic and plastic surgery centres; IVF centres; and even centres of natural health and wellness, concentrate the interest of investors.
In the next chapter, all key concepts (service innovation, corporate venturing, new service development, and customer orientation) are presented along with the rationales behind the development of the conceptual framework. This chapter aims to describe the relationships and the conceptualisations between the four concepts as well as to present the rationale behind the utilisation of the models that come from the review of the literature for the development of the conceptual framework, the customer-driven innovation framework for entrepreneurial growth, and the propositions.
CHAPTER 4

CORPORATE VENTURING AND CUSTOMER-DRIVEN SERVICE INNOVATION

This chapter describes the development of the conceptual framework of the research. Before proceeding with the discussion, Section 4.1 highlights the main domains of knowledge used in this study. This section explains the development of the conceptual framework and its components to provide a holistic understanding of the various perspectives involved in the development of new services and exploitation of entrepreneurial opportunities in the Greek healthcare industry. This approach contributes to the discussions in this and previous chapters of the study. Section 4.2 demonstrates the rationale for integrating the key concepts identified from the literature review in Chapter 2. Section 4.3 presents the conceptual framework and Section 4.4 portrays the customer-driven innovation framework for entrepreneurial growth and describes the five propositions. Finally, Section 4.5 presents the implementation of both conceptual framework and customer-driven innovation framework for entrepreneurial growth in the healthcare market.

4.1 Theoretical foundation of the conceptual framework

Little research has been conducted studying the relationship between innovation and entrepreneurship (Ndubisi, 2014; Zhao, 2005a), with some researchers putting this down to definitional ambiguity regarding both concepts (Soriano and Huarng, 2013; McFadzean et al., 2005). On the other hand, many scholars have carried out studies on customer involvement in service development processes (e.g. Dadfar et al., 2013; Greer and Lei, 2012; Sing Wong and Tong, 2012; Rehme and Svensson, 2011; Svendsen et al., 2011; Jiménez-Zarco et al., 2011). The framework (Figure 4.1) provides an illustration of the main groups of literature that formed the basis for this study. Four theoretical concepts were adopted and studied: Theory of Service Innovation (e.g. Carlborg et al., 2014; Fox et al., 2014; Salunke et al., 2013; Cheng et al., 2012); Theory of Corporate Venturing (e.g. Wei et al., 2014; Efrat, 2014); Theory of Organisational Growth (e.g. Battistini et al., 2013; Dokko and Gabba, 2012); and Theory of Customer Orientation (e.g. Korschun et al., 2014; Witkowska and Lakstutiene, 2014;
Grissemann et al., 2013; Lee et al., 2011). They are classified into two groups (i.e. service innovation and corporate venturing; customer involvement and organisational growth) and are discussed in detail in the following sections of this chapter.

![Figure 4.1 Theoretical framework of the research](image)

The relationships between the key theoretical concepts (i.e. corporate venturing and innovation, and new service development and customer orientation) of this study have been presented in Chapter 2 (see Sections 2.4.3 and 2.4.4). Overall, the study adopts and follows the theories presented by Autio et al. (2014), Tidd et al. (2005), and Bernstein and Singh (2006), who discussed the importance of internal resources and market opportunities for firms to achieve competitive advantage through innovation developments. Similarly, Lerro et al. (2012), Rehme and Svensson (2011), and Windrum and Garcia-Goni (2008) highlight the value of customer involvement in service development; particularly in the healthcare market. Specifically, this study advances the findings of Autio et al. (2014), Efrat (2014), Groene et al. (2014), Mahr et al. (2014), Robertson et al. (2014), and Guerrero and Peña-Legazkue (2013) regarding the means by which innovation is developed and diffused within organizations,
among different entities and across boundaries, verifying that entrepreneurial activities boost firms’ performance and enhance the chances for survival by satisfying customers’ demands. The multi-agent framework of Windrum and Garcia-Goni (2008) is used in the study in an attempt to approach this field of research from a perspective that oversees the dynamics of competition and the potential opportunities for growth along with the current economic and social crisis – which affects, not only the investments, but also the ways in which policymakers regulate in favour or against such initiatives -, and the organisations’ internal capabilities for innovation. This section aims to strengthen these findings by giving more evidence about the effects of these key concepts on business growth and sustainability in the healthcare sector.

4.1.1 Conceptualisation of corporate venturing and service innovation

Many studies focus on strategy, process, or structure of either innovation or entrepreneurship while little has been written about the relationship and synergies between the two (e.g. Nathan and Lee, 2013; Chu, 2013). Some researchers believe that this applies because there is a lack of consensus on the terms’ meanings (Morris et al., 1994) and on the fundamental internal factors that impel both concepts (Mars, 2013; Hornsby, 2002). In contrast, many scholars have worked on the conceptual relationship between entrepreneurship and innovation: Maritz et al. (2015), and Gupta and Asthana (2014). For instance, Sundbo (1998) found three competing paradigms discussed in innovation literature: the technology-economics paradigm, the strategic paradigm, and the entrepreneur paradigm. Other studies add that innovation takes tangible form only when entrepreneurial activities seek to exploit opportunities that come up within firms (e.g. Nambisan and Baron, 2013; Jensen et al., 2013).

Likewise, studies by Belz (2013) and Chatterji et al. (2013) report that the two concepts should be linked together in a business setting, because their combination is the key to organisational sustainability, especially in periods of rapid change. Similarly, studies by Ravix (2014), and Modrego et al. (2014) argued that sometimes entrepreneurship is synonymous with innovation as it aims to generate economic value that provides profits from the market. It comes to attention that both concepts may be formative of means for firms to accomplish growth and differentiation; therefore, organisations should adopt proactive innovation strategies to develop new products and processes and/or create new businesses to achieve corporate survival and to prosper (Autio et al., 2014; Carayannis et al., 2013). Similarly,
Michael and Pearce (2009) performed research aiming to examine how governments innovate and participate in entrepreneurial activities. Their study concludes that innovation requires time, talent and ‘treasure’ as well as infrastructure, capital, and entrepreneurial capacity, to let the previous two operate efficiently (Herbig et al., 1994). Likewise, Zhao’s study (2005a) indicates that innovation meets market needs, and entrepreneurship is the means to commercial success, reporting that “Innovation is the specific tool of entrepreneurship by which entrepreneurs exploit change as an opportunity for a different business or service” (p. 28). Similarly, McFadzean et al. (2005) have undertaken comprehensive research into the connection between corporate entrepreneurship and innovation. Their study develops a sequential framework, combining the definitions of entrepreneurship and innovation (Figure 4.2), and concludes (p. 356) that “a corporate entrepreneur's management of the innovation process will lead to greater benefits for the organisation.” This framework reveals that the main responsibilities of the corporate entrepreneur are to challenge bureaucracy, locate and assess new opportunities, manage and exploit resources and move the innovation process forward to gain benefits for the firm (Karlsson and Warda, 2014; Audretsch and Walshok, 2013).

Furthermore, corporate entrepreneurship has been recognised in the literature as the reliable means of exploiting opportunities for value-creating innovation, ameliorating the competitive positioning of a firm, and promoting corporate competitiveness (e.g. Burgers and Covin, 2015; Andrew et al., 2013; Spencer et al., 2008). Recently, Kelley (2011) conducted a study to explain how firms should include corporate entrepreneurship in their everyday operations, developing systems for improving their entrepreneurial capabilities. Her study demonstrates that corporate entrepreneurship is based on innovation in such forms as a new technology, product category or business model, that lead to a competitive advantage for the firm that develops it. As such, corporate entrepreneurship goes beyond the development of a new product/service or market expansion but is the creation of a sustainable new business for an organisation to enhance its competitive positioning and to provide outstanding value for its customers (Kelley, 2011).
The study by McFadzean et al. (2005) has identified the missing link between entrepreneurship and innovation through the review of the key models of the two concepts. From this study, two major gaps emerge: the lack of explanation with respect to entrepreneurial and innovation dynamics (Cavusgil and Knight, 2015; Marx and Hsu, 2013), and the relation between the corporate entrepreneur and innovation processes (Figure 4.3). The result of this study was to address entrepreneurial vision, actions, and attitudes as the fields that should be explored to clarify the entrepreneurial and innovation dynamics and the relation between entrepreneurship and the innovation process (Figure 4.4).
Figure 4.3 The missing link between entrepreneurship and innovation (Source: McFadzean et al., 2005)

Figure 4.4 Linking entrepreneurship with innovation - attitudes, vision and actions (Source: McFadzean et al., 2005)
In addition, Zhao’s study (2005a, p. 35) found that:

- entrepreneurship and innovation need a management style and an organisational culture that is supportive and innovation-focused;
- entrepreneurship and innovation are complementary activities: innovation is the source of entrepreneurship and entrepreneurship enables innovation to prosper, create value for the organisation and improve business performance;
- innovation and entrepreneurship are dynamic and holistic processes that are not restricted to the initial activity of a new undertaking.

This notion can be also viewed in De Burcharth and Ulhøi’s (2011) recent study, who report that radical innovation usually derives from new business ventures, so established firms who hold a particular interest in developing advanced new products should take this perspective seriously. The study by Herbig et al. (1994) agrees, highlighting the essential connection between innovation and the creation of new ventures. On the other hand, Zhao’s (2005a, p. 36) research concludes that certain difficulties are faced by organisations that choose to enhance their competitive advantages and position themselves through innovation and entrepreneurship. The results of this study underline the need to measure the outcomes of innovations and entrepreneurship, as it is not easy to distinguish between these findings and the total results of the organisation. What is more, technological innovation may bring about job losses, lower staff morale, and other staffing/human resources issues. This finding makes clear the importance of recruiting competent employees and managing them well. Additionally, elements such as risk-taking abilities, time and persistence are needed for a new offering to be successful, while a formal business structure and an independent executive - such as an innovation or entrepreneurship manager - are required to guide the whole process correctly (see more details in Section 2.1 of Chapter 2).

Many studies conceptualise corporate venturing as the actions of individuals or teams within organisations that lead to innovation of processes or products (e.g. Titus et al., 2014; Guerrero and Peña-Legazkue, 2013). Therefore, the concepts of corporate venturing and innovation have been recognised in the organisational sustainability and growth literature. For example, the studies by Corbett et al. (2013), and Antoncic and Hisrich (2003) argue that corporate venturing includes innovative activities that generate new products that sustain the
competitive position of a company while developing new business activities that add value to the parent organisation. On the other hand, the same studies claim that the parent organisation should provide all the necessary resources (financial, knowledge, marketing, and so on) to avail, increasing its speed and levels of innovation. Other studies hold the opinion that corporate venturing is better achieved by large and established organisations (e.g. van der Steen et al., 2013; Yang et al., 2013). They can restructure through strategic renewal, based on gaining new capabilities from smaller ventures. Equally, studies by Evald and Senderovitz (2013), and Greene et al. (1999) argue that corporate venturing can prove an effective option for firms to gain knowledge and skills that often lead to future revenue streams, although research by Tidd and Barnes (2000) reports that, especially in life science industries, many organisations fail to differentiate their strategic, financial, and operational goals, resulting in unsuccessful ventures. For more details about the key factors that influence the success of service innovation and corporate venturing in healthcare, please see Section 2.4, Chapter 2. This section provides the theoretical background and the conceptualisations that have been presented in the literature. It helps the researcher to the base and build upon those arguments, aiming at developing an integrated framework and a research design that will help him to investigate further these concepts in the healthcare context.

4.1.2 Conceptualisation of customer involvement and service innovation

Continuous service innovation has been described in the literature as the most valuable means for companies to achieve long-term success and organic growth (e.g. Weerawardena and Mavondo, 2011; Melton and Hartline, 2010). Some scholars support the opinion that service organisations should focus on the needs and preferences of their customers and turn their innovation efforts in this direction (e.g. Fuchs and Schreier, 2011; Edvardsson and Enquist, 2011). Thus, Marketing Science Institute noticed the importance of customer participation into the innovation process and listed it as one of its top research priorities for 2008-2010.

Likewise, Svendsen et al. (2011), who carried out a study seeking to explore the influence of a company’s marketing strategy on customer participation in new product development, underline that service firms should focus on strategies that prompt and maintain customer interaction to develop services of superior value for the customers. As
regards service development, Kandampully’s study (2002, p. 19) reports “…innovation can be translated as a firm’s foresight to think of the customer by creating services that drive the marketplace (offer superior value to the customer)”. Another study that looks at customers’ value in service development carried out by Jiménez-Zarco et al. (2011). It states (p. 57), “The value that consumers provide derives from their use of services in day-to-day life, which makes their experience and knowledge pertinent, particularly for increasing market acceptance of new services, improving services, identifying market trends early and providing a source of new ideas”. This sentence could be a definition of service innovation responding to market needs. Gao and Chen (2010, p. 1) conducted a research to show a new way of new service development based on customers’ needs. Their study combines the above viewpoints stating that “the principal challenge facing companies is the need to offer the marketplace continuously improved, if not new, services, while keeping one step ahead of their competitors and at the same time fulfilling the needs and expectations of their customers”.

Successful service innovation is likely to involve existing and potential customers in processes both of R&D and of new service development, as the customers’ needs are better understood (Morden, 1989a, 1989b). Studies by Michael and Pearce (2009), and more recently by Grissemann et al. (2013), emphasise that constant innovation and customer orientation are the constitutive elements of company excellence, as innovation derives from the novel approach to responding to customer requirements. In addition, businesses that encourage users to get involved in new service development are superior to their 'conventional' counterparts as they gain more customised ideas for product development, which increases the new product success ratio (Fuchs and Schreier, 2011). This argument reinforces the view that such firms develop and deliver differentiated offerings to their customers, compared to those of their rivals (Svendsen et al., 2011).

Furthermore, the aim of every service firm is to create, satisfy, and keep loyal customers, who speak favourably of the company. New services are developed, answering to the needs of the customers (Papastathopoulou and Hultink, 2012; Krishna and Kautish, 2012). Therefore, user involvement in the new service development process is crucial and has been emphasised in the literature (e.g. Melton and Hartline, 2013; Sing Wong and Tong, 2012; Svendsen et al., 2011; Ottenbacher and Harrington, 2008). This position is enhanced by Greer
and Lei’s (2012, p. 63) recent study, which reports, “collaborative innovation with customers or users is increasingly important for the development of new products and services.” Likewise, the study by Rehme and Svensson (2011, p. 6) investigated the influence of external stakeholders on outcomes and speed to market. It mentions that “firms that involve customers or users in their product development processes are more likely to succeed in the market than companies that do not at an early stage receive feedback from users, and direct customer involvement in the development of their offering is likely to increase revenues with a guaranteed sale, making it necessary for them to have a strategic view of customer involvement”. Similarly, Jenssen and Aasheim (2010), who carried out a study examining how organisational factors affect innovation and performance in small, knowledge-intensive firms, argue that the success of product development depends on the level of market contribution to the development process (see more details in Section 2.4.2 of Chapter 2).

Equally, the studies by Carbonell et al. (2011), Ottenbacher and Harrington (2010) stress the importance of market responsiveness, which links innovation and market-customer demands, engaging close user-contact, comprehensive customer research, and thorough understanding. On one hand, the former study argues that close customer participation increases service advantage and speed to market while lead-user contribution augments the novelty of new offerings and service advantage even though that affects market performance negatively. On the other, the latter research states that companies should understand customers’ needs and respond to market changes, developing differentiated offerings. Additionally, the studies by Gao and Chen (2010) and Grönroos (2007) support that service users ask for quality, style and uniqueness, as against standardised offerings, and, therefore, the design and development of a service should be carried out by people who have a thorough understanding of the needs and wishes of the consumers. In contrast, there might be cases where customers are required to be involved in the decision-making process, but objections will be confronted. For instance, although mental health workers are chary of user involvement in the new service development process (Lewis, 2014; Campbell, 2001), mental service users increasingly contribute to the planning and to the development of new services with advocacy projects, user councils and user-led movements (Lowes and Hulatt, 2013; Newton et al., 2013). For more details regarding the factors that influence patient involvement in mental healthcare, please see section 2.4.4.1 in Chapter 2.
Many studies also highlight the importance of involvement in the service development process, arguing that customers should play the role of ‘partial employee’ and share information with the firm, thus, mutual commitment, trust, adaptations, and relationship management are essential for the development process to flourish (e.g. Witell et al., 2014; Weber and Van der Laan, 2014; Svendsen et al., 2011). Many scholars add that user testing should be part of every stage and a continuous, and extensive contact with leading customers - especially in concept generation and testing stages - is likely to be a success factor (e.g. Mahr and Lievens, 2012; Oliveira and von Hippel, 2011). Studies by Dörner et al. (2011), Lightfoot and Gebauer (2011), and Lin and Hsieh (2014) support this viewpoint, reporting that new services need to be tested before and after their market launch, which is a simple and a low-cost process to eliminate failure. Moreover, the studies by Lau (2011), and Lai et al. (2011) indicate that users are likely to come up with suggestions for improvements during service testing, but the challenge to involve customers requires interdepartmental cooperation, which, nevertheless, enhances the user’s experience.

At the same time, many authors support the opinion that customers have a limited ability to provide valuable input into the development process (e.g. Cheng, Chen et al., 2012; Nicolajsen and Scupola, 2011). For instance, Dadfar et al. (2013), and Edvardsson and Olsson (1996) note that firms should take into account the customers’ needs and wishes via an open dialogue, but should not involve them in the service development process. Mustak et al. (2013) add in their study that customers do not have a virtual and active role in the development of new products, because of the poor connectivity between clients and producers. Also, other researchers argue that the design and development of a new product should be carried out only by professionals (e.g. Thomas and Rothman, 2013; Bringle et al., 2012). Contrary to this view, Grönroos and Voima (2013), and Magnusson’s (2003) studies argue that users provide more valuable and original ideas than do professionals. However, despite such debate, customer involvement remains an underdeveloped research area in the new service development process (Santos and Spring, 2013; Papastathopoulou and Hultink, 2012), and as Peled and Dvir (2013) point out, direct customer participation is rather infrequent. This section provides the theoretical background and the conceptualisations that have been presented in the literature. It helps the researcher to the base and build upon those.
arguments, aiming at developing an integrated framework and a research design that will help him to investigate further these concepts in the healthcare context.

### 4.1.3 Integration of models of corporate venturing and service innovation in the development of the conceptual framework

Several studies argue that corporate venturing promote innovation and is key for companies to achieve long-term growth and improve their competitive positioning (e.g. Crockett et al., 2013; Anokhin et al., 2011; Lin and Lee, 2011). Many researchers have dealt with the venture creation phenomenon and produced models that describe the interaction between the concepts (e.g. Titus, House et al., 2014; Noyes et al., 2013). For example, Shaw et al. (2005) adopted Rogers’ (2003) innovation process model and developed a multilevel framework of corporate entrepreneurship and innovation, divided into macro- and micro-models. The macro-model (Figure 4.5) focuses on the frequency and rate of innovation development, new technological advances, customer’s needs and environmental drivers of innovation. In this case, innovation is mostly driven by customers’ needs (market-pull) or technological advances (technology-push) (Moon et al., 2013; Simon and Yaya, 2012; Von Schomberg, 2012). On the other hand, the micro-model (Figure 4.6) connects the important factors that determine the corporate entrepreneurship and innovation processes. These factors are distinguished into inputs, entrepreneurial catalytic transformation, outputs, contextual factors, and relationships between the different elements.
Likewise, Zhao (2005a) developed the ‘5S’ framework (Strategy, System, Staff, Skills, and Style) to illustrate the interaction between entrepreneurship and innovation. That is: externally- and
internally-focused strategies; control and management systems for R&D and new product development; creative staff members with a desire to innovate; entrepreneurial and managerial skills to address innovation; an entrepreneurial management style for innovation to stimulate organisation’s entrepreneurship and innovation efforts. Another study by Chen et al. (2005) (Figure 4.7) indicates several factors that synthesise into a hypothetical system model which increases a corporation’s commitment to corporate entrepreneurship and innovation (Onetti et al., 2012; Goodale et al., 2011):

- entrepreneurial quality refers to the quality of staff (people with entrepreneurial insight, with a flair for innovation);
- the system of the board of directors and management (promotion of long-term and risky projects, fostering corporate entrepreneurship and innovation (Bantel and Jackson, 1989)) and
- corporate strategic entrepreneurial management that enhances corporate entrepreneurship (Igel and Islam, 2001) and those circumstances that benefit the growth of corporate entrepreneurship.

*Figure 4.7 The hypothetical system model of cultivating corporate entrepreneurship (Adapted from Chen et al., 2005)*

Some other studies focus on the linkage between individual and environment. For example, Dokko and Gaba (2012), Anokhin et al. (2011), and Vuori et al. (2012) found that the interaction of the individual and the environment is one of the most substantial parts of the corporate venturing process. Many of those studies were based on Martin’s research (1984), which found that several features (e.g. partial social alienation, psychological/physical
predispositions, demonstration effects, family factors, and precipitating events) create a moment in time for the individual-organisation. When this co-occurs with the identification of a new venture opportunity, the access to financial support and a supportive environment conclude in a likely new venture. Likewise, the study by Hornsby et al. (1993) aimed to describe a model (Figure 4.8) that explains how the individual-organisational characteristics that cooperate with precipitating events led to fruitful and profitable new ventures. When those characteristics cooperate with precipitating events, the decision to act intrapreneurially is positive, and this leads to the development and implementation of a dynamic business plan. It is also important for the parent organisation to provide all the necessary resources for the development of the new venture, while it is crucial to transfer the appropriate knowledge and build the proper structure, helping the new venture to overcome any difficulties.

Figure 4.8 An interactive model of corporate entrepreneurship (source: Hornsby et al., 1993)

This last section underlines the importance of both, external and internal, environments of a company and their impact on organisations’ innovation and entrepreneurial plans and activities. It also demonstrates that combining these two concepts, firms are likely to explore and identify new opportunities. The above arguments lead this research to include both concepts and consider them as critical components of the conceptual framework below (see
Likewise, several researchers have dealt with the benefits and limitations of customer involvement in the new product or service development process, while a smaller number have identified successful techniques that show how this could be better implemented: Quality Function Deployment (Griffin, 1992); Consumer Idealised Design (Cinciantelli and Magdison, 1993); Beta Testing (Dolan and Mathews, 1993) and Leader User Analysis (von Hippel et al., 1999). However, Alam (2002) reports these techniques as an engineering driven, involving users at the design and the manufacturing stage of the product development process; this is applicable mostly in construction and engineering enterprises.

Many studies highlight that successful new services emerge from a dialogue between provider and user (e.g. Hoyer et al., 2010; Bonner, 2010; Melton and Hartline, 2010). For example, Witell et al. (2011, p. 9) carried out a study to identify the differences between proactive and reactive market research techniques during the development of new products. They found that customer involvement creates value for businesses with “...activities in which customers actively participate in the early phases of the development process by contributing information about their needs and/or suggesting ideas for future services that they would value being able to use”. Likewise, Sigala (2012b), and Peled and Dvir (2012) describe a customer active paradigm that should be developed when formulating and testing the service concept and implementing service processes. They focus on service quality, involving customers in the development process. In this case, the company is responsible for developing a service concept, taking into account the needs of the users and offering a quality service using the service system, and for providing the required resources for service development. Again, Cooper (1988, p. 248) developed a systematic process model for new product development, putting considerable emphasis on market orientation. He proposes that market orientation should be a matter of routine in any new product process, as marketing inputs increase product success. Thus, he suggests seven marketing activities that enhance the efficiency of the development process:

1. preliminary market assessment to identify the market acceptance of the new product concept;
2. market research to design the new product according to the needs and preferences of the customers;
3. concept testing with users to acknowledge the reactions and intentions of potential customers;
4. analysis of the competition;
5. tests with users to ensure good performance of the new offering;
6. market testing in a limited geographic area would show how the marketing mix works and
7. full market launch, based on a marketing plan, providing the necessary resources.

Alam (2002) performed a comprehensive research study involving business customers/users in most of the ten stages of the new service development process. He concluded that users benefit the process at all stages (Table 4.1), but the intensity of the involvement depends on the particular characteristics of each phase. This argument means that at the initial stages of idea generation and screening and the later stages of service testing, test marketing, and commercialisation, customers should participate intensively. It may be achieved by interviews with customers, user visits and team meetings, user observation and feedback, focus groups, and so forth. However, Alam suggests that the first two modes appear as the most ascendant in customer involvement. Recently, Hoyer et al. (2010) analysed consumer co-creation at different stages of new product development. Their study suggests that firms should exploit new technologies to create value with customers in a more complete and professional manner. The studies by Romero et al. (2014), Brockhoff (2013), and Sigala (2012a) take a similar viewpoint, mentioning that new technologies, such as social media, can extend the width and profundity of inputs, helping firms to share the development concept with customers and ask for their contribution. Hoyer et al.’s study (2010) adds that such technology can be a useful tool for firms, as it lets product adopters send their feedback in less time than with traditional techniques. It allows companies to understand relatively quickly the causes of low repurchase rates and improve some features of the product while it is on the market, aiming to decrease adverse effects of the potential failure (Dong et al., 2008).
Table 4.1 Activities at various stages of the development process

<table>
<thead>
<tr>
<th>Development stage</th>
<th>Activity performed by the producers</th>
<th>Activity performed by the users</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strategic planning</td>
<td>Chart the direction; corporate objectives; mission of the business. Identify users for involvement to leverage users’ expertise</td>
<td>Limited feedback on proposed plan for new service development</td>
</tr>
<tr>
<td>2. Idea generation</td>
<td>Internal and external search for the ideas. Probe customers' needs, wants, and preferences and their choice criteria, likes, and dislikes; seek competitive product ratings</td>
<td>State needs, problems, and their solution; criticise existing service; identify gaps in the market; provide a wish list (service requirements); state new service adoption criteria.</td>
</tr>
<tr>
<td>3. Idea screening</td>
<td>Feasibility analysis; attribute analysis; gather users' problems and their solutions; elimination of weak concepts by analysing how these meet users' needs; assess customers' purchase intent; look for patent legal and regulatory issues</td>
<td>Suggest rough guide to sales and market size; suggest desired features, benefits, and attributes; provide reactions to the concepts; liking, preference, and purchase intent of all the concepts. Help the producer in go/no-go decision</td>
</tr>
<tr>
<td>4. Business analysis</td>
<td>Economic analysis to justify the project, that is, payback analysis and net present value; market assessment, profitability analysis; drafting of budget for each concept; commitment of resources by top management; detailed competitive analysis</td>
<td>Limited feedback on financial data, including profitability of the concepts, competitors' data</td>
</tr>
<tr>
<td>5. Formation of cross-functional team</td>
<td>Adopt a team approach and select a team leader; induct users into the team; ask each team member to adopt a role he/she would prefer to play in the development process</td>
<td>Join top management in selecting team members</td>
</tr>
<tr>
<td>6. Service design and process/system design</td>
<td>Combine the service attributes identified earlier with their delivery process, including service delivery personnel; map this process jointly with the users; develop documentation and final service design blueprinting; find out service delivery time; install, refine, and debug the service delivery mechanism</td>
<td>Review and jointly develop the blueprints; suggest improvements by identifying fail points; observe the service delivery trial by the firm personnel. Compare their wish list with the proposed blueprints of the service.</td>
</tr>
<tr>
<td>7. Personnel training</td>
<td>Train the service delivery workforce; prepare them for encounters; manners and attentiveness are the key criteria; ensure consistent service quality</td>
<td>Observe and participate in mock service delivery process; suggest improvements</td>
</tr>
<tr>
<td>8. Service testing and pilot run</td>
<td>Test the blueprint; implement design change and refinements; test to prove the service under real-life conditions; determine users’ acceptance of the service</td>
<td>Participate in a simulated service delivery processes; suggest final improvements and design change</td>
</tr>
<tr>
<td>9. Test marketing</td>
<td>Develop marketing plan and test with the users; examine the saleability of the new service; examine the marketing mix options in different markets; limited rollout in the selected market</td>
<td>Comments and feedback on various aspects of the marketing plan; detail comments about their satisfaction with marketing mixes; suggest desired improvements</td>
</tr>
<tr>
<td>10. Commercialisation</td>
<td>Plan promotional campaign; appoint distributors and brokers; roll out in the market; look for potholes; modify according to the market conditions</td>
<td>Adopt the service as a trial; feedback about overall performance of the service along with desired improvements, if any; word-of-mouth communications to other potential users</td>
</tr>
</tbody>
</table>

(Source: Alam, 2002)

Somewhat differently, Bonner’s study (2010) demonstrates how customer interactivity has a positive impact on new product performance through customer information quality. Although product performance refers to product quality, technical performance, and ability to meet
customer needs, this study develops a framework (Figure 4.9) that links it to the product development process. For instance, if customer needs and preferences have been identified at the beginning of the development process, the performance of the new product is likely to be high. For more details regarding the factors that influence the success of customer orientation, please see Section 2.4.2, Chapter 2.

Many studies raise this issue, mentioning that customer orientation, market knowledge competence and user involvement programmes among others have been positively linked to new product performance outcomes (e.g. Mahr and Lievens, 2012; Belkahla and Triki, 2011; Kowalkowski, 2011). Likewise, Melton and Hartline (2010) developed a framework (Figure 4.10) that illustrates the effects of customer and frontline employee involvement in new service development. They concluded that customer and frontline employee contribution to particular stages of the new service development process indirectly benefit sales performance and project development results. They also suggest that firms should engage consumers in the design and development stages to produce and assess new service proposals, provide feedback for service offerings and attain market expansion. Companies should exploit frontline personnel in the market launch phase to support and deliver the new outcome.

Figure 4.9 Customer interactivity framework (Source: Bonner, 2010)
Another rationale that puts customers at the centre of the new service development process is the customer concept. The aim of this concept is to precipitate customers into making the firm their first or sole choice. A study by Vandermerwe (2003) emphasises that service organisations should not only develop and sell services, but also implement a customer-focused strategy to become ‘indispensable’ to the customer. Hence, companies should apply a proactive service innovation strategy to increase the self-reinforcing loop (Figure 4.11), deterring competitors from exploring and exploiting market gaps. The lock-on loop is based on shared information and collaboration between firms and customers. It allows firms to offer more value to their customers, always considering that their needs change over time. This notion leads to satisfied and loyal customers, providing sustainable competitive advantages to the producer.
Customer interactivity and information quality

The relationship between customer interactivity and customer information quality is moderated by product newness and product embeddedness. For example, studies by Bonner (2010) and Narver et al. (2004) have shown that customers are incapable of providing accurate feedback for brand new products, as they are unfamiliar with their applications. Therefore, companies should build an efficient interactive communication with customers, using tools and methods that promote information and knowledge sharing (Grönroos, 2012). Bonner’s study (2010, p. 3) states, “high customer interactivity consists of such rich, face-to-face channels, and facilitates the learning process between customers and NPD organisation. It reduces ambiguity associated with how really new products will be used and valued.”

Additionally, studies by Stanko and Bonner (2013), and Singh (2011) argue that customer interactivity is positively related to and enhances customer information quality when there is high product embeddedness in the customers’ systems and procedures. This study describes the way that highly-embedded products involve high ambiguity in decision-making because they increase the complexity and range of customers’ requirements while decreasing customers’ ability to express their needs and wishes to the product development team. This requires tools and methods - such as face-to-face meetings, joint problem-solving and rich information channels -, which can resolve this ambiguity. At the same time, low-embedded products do not require high interactivity, as this leads to lower quality information. Highly interactive processes result in fewer customers offering input, which in turn leads to missed customer requirements in the product development project. Daft and
Lengel (1986) add that in such conditions, more focused and less interactive methods should be used to obtain customer information.

On the other hand, several studies claim that customer interactivity is not related to customer information quality, because high customer involvement may reduce the overall quality of information (e.g. Ganguli and Roy, 2011; Berthon et al., 2004). Bonner’s study (2010, p. 3) explains this, reporting that “a highly interactive process requires more team effort per customer, resulting in fewer customers contacted, as compared to a less interactive process. Therefore, limiting the touch points on the market with an interactive process might cause the product team to miss valuable customer information...and) might add unneeded distractions and confusion”. It has been clear that customer involvement benefits the new service/product development process and performance, as new service success depends on understanding and satisfying customers’ needs. This argument leads to the conclusion that high new product performance is achieved when high-quality customer information is used. Cheung and To (2011, p. 5) expand on this viewpoint, stating that “…the level of co-production is a good moderator that strengthens the positive link between customer involvement and perceived service performance in terms of tangibles, reliability, empathy, and assurance”.

This second part of this section underlines the importance of customers and users in new service development as well as the benefits and limitations of their involvement in organisations’ innovation activities. It also demonstrates that combining these two concepts, firms are likely to explore and identify new opportunities for customised services, which is critical for the sustainability of the healthcare organisations, in particular, those who operate within the mental health sector (for more details see section 2.4.3). The above arguments lead this research to include both concepts and consider them as critical components of the conceptual framework below (see section 4.4).

4.2 Development of conceptual framework: Corporate venturing and customer-driven service innovation in mental healthcare

The formulation of the conceptual framework (as shown in Figure 4.13) was guided by a recognition of the domains of knowledge as illustrated in Figure 4.12. This figure presents the
review of the literature along with the research context as two domains of knowledge. To create the conceptual framework, all essential knowledge concerning the Greek healthcare industry and all factors causing the development of new services were extracted from these domains. The nexus of these domains is described in sequence as follows: The first domain is related to Chapter 3, which presents an overview of the current condition of the Greek healthcare industry, and the role of the private sector in particular. The second domain is related to Chapter 2, giving details concerning service innovation and the key concepts of new service development, corporate entrepreneurship, and customer orientation.

![Figure 4.12 Domains of knowledge used to develop the conceptual framework](image)

Section 4.2, as presented earlier in this chapter, concern the rationale of the relationships among the main concepts in this study, and it has been aimed at highlighting several issues regarding innovation and business growth in an attempt to recognise multiple perspectives and to develop a well-founded conceptual framework. The current literature concerning the concepts of service innovation, corporate venturing, new service development and customer orientation as well as the healthcare industry as the research context of this study have been used for the development of the conceptual framework below.
The review of the literature (Chapter 2) has shown that developing new and innovative services can offer organisations stability or growth in their respective markets, or even repositioning and entry into new markets (e.g. Sharma et al., 2014; De Burcharth and Ulhøi, 2011). It also appears that in knowledge-intensive industries, such as healthcare, customer involvement in service development is often extremely advantageous (e.g. McColl-Kennedy et al., 2012; Berry and Mirabito, 2010). Based on these findings, a conceptual framework has been developed (Figure 4.13) to address the following research questions:

1. Where, how and why should patients be involved in new service development?
2. How do medical personnel perceive patient involvement in new service development?
3. What is the role of medical personnel in patient-oriented service development?
4. How and to what extent is corporate venturing developed by adopting service innovation initiatives?

Following the rationale behind the development of the conceptual framework (Section 4.2), the figure below aims to conceptualise the new service development and corporate entrepreneurial activities in the healthcare industry. It offers a holistic approach to strengthening an organisation’s position in the healthcare market by developing new service offerings and identifying business prospects while satisfying and gaining loyal customers. From a theoretical perspective, this framework highlights the interactions between the research concepts within an organisation, as well as the entrepreneurial and new service development opportunities within the mental health and rehabilitation sector. The framework is developed to guide research efforts and to provide insights for managerial practice. The proceeding section of this paper explains the elements of the framework.
Figure 4.13 Conceptual framework for service innovation and corporate venturing in the mental healthcare industry

Figure 4.13 recognises that competition in the healthcare industry and environmental uncertainty are the key external driving forces that require the organisation to pursue strategies for growth. As has been shown in the research context (see Chapter 3), the health service industry is now characterised by increased competition and the growth of large enterprises offering a wide-ranging selection of services. Consequently, this has led to a decrease in the number of smaller specialised firms. The second driving force is the instability of the Greek healthcare industry. It is the result of many factors; firstly, as Greek political power is frenetic in its lack of longevity (with leading political parties, possessing power only
for what is often a very short time), policy regarding healthcare is continually changing. Secondly, there are many problems regarding cash flow and payment delays by insurance funds, and in turn for hospital funding and revenues due to the current economic crisis and capital liquidity shortage. Lastly, great concern is felt by many Greek citizens regarding hospital fees. It is important to mention that the conditions of competition in the Greek private healthcare market and the political, business, and social climate in Greek society are major forces pushing healthcare organisations to seek innovation and to exploit every business prospect.

Figure 4.13 also portrays two driving forces that urge firms to undertake several initiatives and approaches related to their growth. These are classified into four research efforts: service innovation, corporate venturing, new service development, and customer orientation. The combination between the first two seems to play a significant role in the identification and exploitation of entrepreneurial opportunities while the interplay of the latter two contributes to the creation of satisfied customers. Many authors believe innovation and entrepreneurial activities to be intrinsically linked (e.g. Shepherd and Patzelt, 2011; Schaltegger and Wagner, 2011). We may conclude that entrepreneurship and innovation are complementary activities, with innovation as the source of entrepreneurship and entrepreneurship enabling innovation to prosper, create value for the organisation, and improve business performance (Ndubisi and Agarwal, 2014; Zhao, 2005a). Likewise, many researchers conceptualise corporate venturing as the actions of individuals or teams within organisations that lead to innovation of processes or products (e.g. McKelvie et al., 2014; Gaba and Bhattacharya, 2012). Conversely, some authors support the view that service organisations should focus on the needs and preferences of their customers and turn their innovation efforts in this direction (e.g. Paasi et al., 2014; Fuchs and Schreier, 2011).

Successful service innovation is likely to involve existing and potential customers in the new service development process. In so doing, the customers’ needs are better understood (Greer and Lei, 2012). It is clear in the literature that inputs of information about actual and potential customers guide effective and customised offerings (Hsieh and Hsieh, 2012; Kuusisto and Riepula, 2011). Grönroos’s study (2007) suggests that the development of a new service offering should be implemented by people who fully understand the requirements and the
preferences of the customers. This idea is particularly valid in mental health services, as user participation improves the psychological situation of the patient and enhances the quality of the offering. This leads to a more active user, who can contribute to his/her treatment.

4.3 Development of a new framework for customer-driven innovation and entrepreneurship in healthcare

The research context of this thesis revealed that the competition between private health units is particularly intense and focuses primarily on the replacement of medical equipment; the range and quality of the services provided; the speed of the services offered; the extension of networks; and the cooperation with insurance funds. Additionally, the long-term rise in living standards, the gradual ageing of the population, the emergence of new diseases, and the increasing number of people covered by private insurance companies contribute to the progressive increase in demand for private health services and preventive medicine (NSSG, 2011). Moreover, the evolution of medical science in conjunction with the evolution of technology in the health sector, have increased demand for direct, efficient, and quality health services. Furthermore, the countries of Eastern Europe and Turkey appear to concentrate the interest of investors of the large Greek business groups (ICAP, 2009). Additionally, the geographic imbalance of private hospitals creates growth opportunities. Finally, provision of day nursing services, rehabilitation centres, and geriatric hospitals are areas that concentrate the interest of investors. These many and various factors are consistent with the studies of Kelley (2011) and Zhao (2005a) touch the first research question from the competition point of view and along with the research questions lead to the development of the customer-driven innovation framework for entrepreneurial growth (Figure 4.14). The customer-driven innovation framework for entrepreneurial growth is a graphical representation of the dynamics between competition, new service development and customer orientation in healthcare, as those are described and illustrated in the conceptual framework (Figure 4.13), aiming at showing the links with the emerging entrepreneurial for both new service and business development. The above arguments about competition and the potential openings in the unexplored areas of the healthcare market along with the benefits of entrepreneurial innovation and corporate venturing form the first key principle for the development of this customer-driven innovation framework for entrepreneurial growth (Figure 4.15), and the
following proposition, which is linked to the fourth research question as service innovation is a critical element of the market due to competitive dynamics often pushing for corporate venturing actions:

Proposition 1: Strong competitiveness in the healthcare business sector is likely to induce more business openings. Thereby, further business growth will be generated in underdeveloped sectors of the healthcare service industry through corporate venturing initiatives.

Figure 4.14 Developing the Customer-driven innovation framework for entrepreneurial growth
4.3.1 Venturing activities and service innovation in healthcare

Corporate entrepreneurship is often associated with competitive success and is said to be achieved through various methods (Andrew et al., 2013). Other studies argue that corporate entrepreneurship is a strategic tool that leads firms to exploit opportunities, create value, and increase their innovative competence (Bloodgood et al., 2013; Kraus and Rigtering, 2010). In particular, corporate venturing can often involve high-risk activities, such as the introduction of new products, entry into new markets, and establishing new companies (McGrath et al., 2012; Lin and Lee, 2011; Narayanan et al., 2008).

The healthcare industry is one characterised by innovation (Page, 2014; Burns, 2012; Thakur et al., 2012), with hospitals often acting as leaders in innovation as new treatments and technologies in this arena emerge daily. In the healthcare market, many firms choose to
develop their business through corporate venturing, establishing alliances with smaller businesses to develop and deliver new health services.

However, this rapid rate of change can often stifle organisations that may not have the resources to keep up and will end up suffering from business inertia (Rohrbeck and Gemünden, 2011). Other potential problems regarding innovation in healthcare lie in the bureaucracy and other such problems often associated with the industry (Duncan and Breslin, 2009; Bellou; 2010). Efforts to ameliorate problems and issues such as these have been illustrated in research by various authors (e.g. Thakur et al., 2012; Menor and Roth, 2007; Nijssen et al., 2006) who suggest a rigid, systematic approach to new service development as being able to provide a more efficient approach to successful innovation, which might lead to the exploration of entrepreneurial opportunities. The above discussions form the second key principle for the customer-driven innovation framework for entrepreneurial growth, and the following proposition, which intersects with the fourth research question as regards the exploitation of service innovation in corporate venturing:

Proposition 2: Entrepreneurial opportunities addressed to healthcare organizations may be discovered by enriching business development processes with innovative services.

4.3.2 Customers and new health service development

New service development activities enhance current business and create the potential for new business ventures (Fairman, 2013; Weng et al., 2012). The need to develop new services is of particular importance in the healthcare industry due to the nature of the services provided. On the other hand, the study by Melton and Hartline (2010) notes that customer participation in the design stage increases efficiency and sales of the new development. This point is particularly relevant to the healthcare industry as health services need to be tailored to individual patients, adapting to medical needs to be effective (McColl-Kennedy et al., 2012; Berry and Mirabito, 2010). Other studies highlight the contribution of customers in idea generation, noting that customers appear keen to participate in such activities, assisting companies to develop superior customised offerings (e.g. Swan, 2012; Steen et al., 2011; Hoyer et al., 2010). The above form the third principle for the customer-driven innovation
framework for entrepreneurial growth, which is linked to the first research question in terms of the role of patients in new health service development. It also addresses the second and third research question, which examines the perceptions of medical staff about the involvement of patients in the development process. All these arguments lead to the following proposition, which supports patient participation in the idea generation process, following the findings of Alves et al. (2013), Ennis and Wykes, (2013), Staniszewska et al. (2013), Tambuyzer et al. (2014) that report the benefits of patient participation in the service development process:

Proposition 3: A number of new service opportunities will be created by implicating patients in the ideation process.

There are studies that suggest that firms should become customer-oriented, developing highly customised services that meet customers’ needs (e.g. Javalgi et al., 2014; Salunke et al., 2013). As regards healthcare, studies have shown that patient involvement enhances health services, reduces complaints, and raises customer satisfaction (e.g. Groene et al., 2014; Tambuyzer et al., 2014; Avise et al., 2014). In particular, it has been demonstrated that mental health patients can benefit service planning, development and delivery (Rise et al., 2014; Ennis and Wykes, 2013; Victorian Mental Health Service, 1999). The above discussions illustrate the importance of customer participation in the new service development process. This argument forms the fourth key principle for the customer-driven innovation framework for entrepreneurial growth. The following, fourth, proposition is linked to the first research question, which investigates the ways in which patients should contribute to the development process, assuming that such contributions will lead to successful outcomes, following Melton and Hartline’s (2010) conclusions that customers contribute to the generation of new service opportunities:

Proposition 4: Customer-oriented services will be generated by involving mental health service recipients in service development process.

By embracing the above-mentioned activities, organisations provide themselves with the opportunity to achieve two aims: identification of entrepreneurial opportunities that emerge in the healthcare industry on the basis of which to develop successful innovation strategies,
and the development of tailored services to effectively satisfy user needs. By achieving these aims, the organisations in question will be able to bolster their competitive position and gain competitive advantages in mental healthcare services. This argument forms the fifth principle for the development of a customer-driven innovation framework for entrepreneurial growth. The following, fifth proposition integrates the four research questions. It assumes that patient participation (incorporating service users, family members, and medical staff) will lead to service innovation, which is an important tool for a company in exploiting entrepreneurial opportunities (e.g. Avise et al., 2014; Alves et al., 2013; Bellou, 2010). The fifth proposition is described as:

**Proposition 5:** Business expansion opportunities will stem from exploiting new business openings by implementing new mental health offerings centered on the customer.

### 4.4 Application of conceptual framework and of the customer-driven innovation framework for entrepreneurial growth

Both the conceptual framework and the customer-driven innovation framework for entrepreneurial growth are used to describe the relationships between the key concepts of this study. They have also been used as guidelines for creating the questionnaires (see Appendices 1 and 2) for the two phases of the research (for more details, see the methodology chapter below). The questions in the questionnaires represent the factors and the concepts in the conceptual framework as well as they aim to validate the propositions that have been developed and presented in Section 4.4. The two research sections involve discussion of these concepts and their effects on organisational growth and sustainability that emerge from corporate venturing and customer-oriented new services. They also include experts’ experiences and recommendations about how these concepts can be implemented in practice. The results may be used not only for the case organisation but also from other organisations in the healthcare industry to improve their ability to innovate and exploit opportunities by using customers’ insights and knowledge.
The link between the research questions and propositions

There is an obvious interconnection between the emerging model and gathered evidence throughout the data gathering and writing. In doing so, numerous elements suggested by the literature and prior researchers are grounded in evidence, while others are not. Other elements proposed or suggested were retained but were modified considerably to conform to the evidence. The knowledge gaps identified led to the research questions above (see Section 4.3). Five propositions - which were emerged from the literature review and the methodological framework applied - underpin those issues and are used as the medium that will address the research gaps. Section 4.3 has presented and explained that Proposition 1 is linked to RQ4, as competition is a fundamental element of the market, and the literature has shown that competition is likely to lead to the development of new offerings in order a firm to remain current and competitive. Likewise, Proposition 2 intersects with RQ4 as it links service innovation with corporate venturing and its impact on the identification of entrepreneurial opportunities. Proposition 3 is related with RQ2, as it aims to investigate the perceptions and thoughts of medical personnel regarding patients’ involvement in the new service development process, which can be an important addition to the new service development process. Proposition 4 is related to both RQ2 and RQ3, as it aims to examine the benefits of patients in service development process, but it is also important to study the perceptions of medical staff in involving patients in the process. The last proposition emerges from all the research questions, as it aims to provide a complete picture around the growth opportunities that will emerge when healthcare organisations exploit opportunities for business expansion by developing customer-oriented new services.

The methods of data collection and analysis used in this study draw on recommendations by Ritchie et al. (2013), Bradley et al. (2007), and Carter and Henderson (2005). The methods include a continuous comparison of data received and model created throughout the research study. The next chapter begins by presenting the research approach and philosophy of this study, following the research strategy. Here, the rationale for employing face-to-face in-depth interviews is described and explained. Also, the development of a research framework based on existing literature, research questions, and the conceptual framework presented above is illustrated. This research model helped the researcher to form
the three different sections of data collection and also served as a guidance for the identification of the research instrument.
CHAPTER 5

EXPLORATORY STUDY AND RESEARCH METHODOLOGY

5.1 Introduction

So far, this study has presented the industry context, showing that intense competition in the healthcare industry leads firms to innovative activities to remain current and competitive. The area for growth was also identified; in particular, the mental healthcare market in Greece. The review of the literature set the basis for understanding the profound meaning of service innovation and the importance of a service innovation strategy and process in determining the innovation goal as well as the activities that should be adopted for the development of the new offering. Moreover, the literature on innovation illustrated the significance of innovation activities within the healthcare industry. Additionally, the definition of corporate entrepreneurship and the exposition of the value of corporate venturing in exploiting business opportunities and market expansion have furthered the development and analysis of the service-provider related side of this research. Furthermore, the review of the literature has helped the researcher to identify the potentially major contribution of customer involvement in the new service development process to develop new outcomes that fulfill users’ needs and preferences. As regards the mental health industry, patient participation has been reported as critical to the experience and the well-being of consumers.

Phased research is adopted as the research methodology with each phase highlighting issues that need to be focused on in subsequent phases. The research questions presented in Section 1.3 in Chapter 1 and the conceptual framework direct the form of the two phases of the research design (see Figure 4.13). As Baxter and Jack (2008), and Miles and Huberman (1994) state, the conceptual framework that presents the system of concepts, assumptions, expectations, and theories supporting the research is a critical part of the research design (c.f. Maxwell, 1996). In this study, the research was designed as indicated in Figure 4.13. First, after the purposes of the study were stated, the literature involved was reviewed and critiqued. Then the conceptual frameworks were generated. This process led to the addressing of the
research questions. Then, data were collected and analysed based on the phase they were placed in.

5.1.1 Purpose and value of qualitative research

Qualitative approaches to healthcare research have the advantage of illuminating aspects of care quality than cannot be accounted for through the facts and numerical-data basis of quantitative research (Holloway and Wheeler, 2013; Green and Thorogood, 2013). Though rigorous in providing valid and standardised results, quantitative enquiries cannot give answers to complex meanings, explain the views of different social agents-patients included, and also raise critical social issues embedded in healthcare such as ethics, power relations, respect, justice, and so on (Holloway, 2005). By employing techniques such as focus groups, in-depth interviews and field observation, qualitative researchers aim to explore the views, experiences, attitudes, and interactions of patients in the context of healthcare relationships, which gives them an increased understanding of the meanings, which in turn give form and content to social processes (Mörtl and Gelo, 2015). Qualitative research is an interpretivist and descriptive model of research analysis, which centres on the concept of the subjective realities of individuals and the meanings attached to them (Banister et al., 2011). Any interaction in the social sphere is always context-bound and subjective, which places the work of the researcher on the level of reflective reconstruction and interpretation of the actions of other people (Holloway and Wheeler, 2009). Moreover, as research progresses the researcher can even provide a reflective account of his own evolving understanding as a learning process (Haynes, 2012). Since complete objectivity and neutrality are impossible to achieve, the values and assumptions of the researchers should be accounted in research analysis. The outcomes and conclusions of any qualitative research project are unique since they are dependable on the history and temporality of the contextual conditions permeating the study (Curry et al., 2009). This is a process, which is developmental and dynamic in character with conclusions often generated and altered simultaneously with the ongoing process of research. Qualitative methods encompass these processes and changes over time in the culture or subculture under study.

In addition, qualitative research methods acknowledge patients as equal, active partners in the context of healthcare provision, which is important in giving a voice to seldom-
heard or marginal groups such as the elderly, mental health patients, addicts, minorities, etc. (Green and Thorogood, 2013; Pope and Mays, 2008). The conclusions of such methods are very important as they can shed light to the contextual complexities and differences in healthcare practice dynamics, influenced by the views, values, and beliefs of participants and the power relations in healthcare settings. They can provide detailed, descriptive reports on day-to-day practice and provide suggestions for improvements or set new theoretical questions emerging from the ongoing research (Holloway, 2005). Under these circumstances, evaluation is seen as the means through which to develop, improve, and progress the project or programme evaluated. Patton (1999) states that the focus is increasingly on its concurrent potential to inform and empower, a facet particularly important amongst stakeholders at grassroots level. Qualitative research methods are based on the premise of subjectivity and thus encourage the input from different stakeholders (Coolican, 2014). However, in the context of medical and scientific research, qualitative methods have been questioned for their subjectivity and lack of factual, objective results. It is reported that medical researchers find it hard to apply standards proposed by social scientists, which may be valid or useful in their discipline, but do not necessarily count for generically valid scientific standards (Morse, 2012; Sandelowski, and Leeman, 2012).

To counteract the shortcomings of qualitative methods, researchers collect data from a multiplicity of sources and perspectives, employing various data collection methods. Making such methodological choices is subject to a number of factors: the credibility and validity as well as the capabilities of the participants in the study. Davies and Dodd (2002) suggest that such choices should be reflexive and responsive to avoid procedures, which impose inhibiting controls. Valandra (2012) and Patton (1999) stressed the importance of continuous strategizing, adaptation, prioritising, and relevance in the evaluation process. Pope and Mays (2008) suggest the following procedures to improve validity: triangulation, respondent validation, clear detailing of data collection and analysis, reflectivity and attention to negative cases. They also suggested the use of detailed reports and sampling techniques as a means to increase relevance. Giacomini et al. (2009) have also emphasized the importance of clinical relevance. Researchers use methodological triangulation, which is divided into two different forms: intra-method triangulation and between-method triangulation. In the case of the former, different strategies are adopted within the same paradigm, while the latter involves
testing the validity of a certain method using another qualitative method. It is generally maintained that triangulation improves validity and reduces the bias inherent in one method (e.g. Guion *et al.*, 2011; Perlesz and Lindsay, 2003). Whatever data collection methods are chosen, qualitative research involves a strategy of inductive inference based on the analysis of statements made by the participants (Palinkas *et al.*, 2013).

This strategy follows the following steps: first, the interviews are transcribed, and then the material is carefully examined several times and the fragments, which are deemed as significant or meaningful, are classified fitted into wider, generalised themes. At this final stage, it is useful to draw on the conclusions of other studies - small or large scale, quantitative or qualitative - it can be either case. Afterwards, the data elicited can be compared to relevant published data from other studies (Schonfield and Farrell, 2009; Seale, 1999). By selecting a few representative examples, the researcher can come to conclusions and produce generalised assumptions, which go beyond the individuals under study as these conclusions underline overarching themes and structures (Ritchie *et al.*, 2013). As an example, Kumar and Gantley (1999) carried out a study, interviewing forty-four GPs, which revealed that their generalist concerns contradict the specialist concerns policy makers expect them to develop if they are to implement new genetics into their practice. The researcher when adopting qualitative research methods must assume a reflective stance in assessing their role and involvement in any stage of their study. This is of outmost importance in terms of the reliability and validity of their chosen research methods and their way of implementation. Accounting for any bias or skewness in the methodological approach adopted, reinforces the study’s credibility and transferability of findings (Van Maanen, 2011). The external validity of the research project results depends on whether these can be applied to other settings. Researchers in qualitative analysis should bear in mind that generalisations cannot be of the same scope as in quantifiable sampling methods. The pursuit of qualitative analysis lies in the contextual interpretation of textual material in specific settings.

5.1.2 A hybrid approach of inductive and deductive coding to understand social phenomena

There is a wide range of literature that documents the underlying assumptions associated with qualitative data. These stem from various traditions or approaches such as grounded theory
(Corbin and Strauss, 2014), phenomenology (Van Maanen, 2001), discourse analysis (Wodak and Meyer, 2009) and narrative analysis (Georgakopoulou, 2006). A strategy in qualitative research, which was considered relevant and purposeful for the objectives of the present study, is the inductive approach (Gioia et al., 2013; Bryman and Bell, 2007). The key feature of the inductive approach is that it is guided by the objectives set on the outset of the research project. Key themes under this approach can be reframed, so the entire research construct is adaptable. Findings emerge through the frequent re-examination, re-appraisement of the raw data, something that is impossible in more structured methodologies. The inductive approach requires that there are clear and transparent links established between the research objectives and the findings, which derived from the raw data. This way both the transferability and the validity of the research project are secured. The inductive approach is frequently employed in health and social science research for the reason that it is instrumental in developing concepts about social phenomena in natural settings, giving emphasis on the lived experience of participants. It is an important approach, which establishes causal links between the interrelations of the different social agents under study in specific social/interpersonal settings. It is also an approach, which requires a rigorous and systematic reading and coding of the transcripts, which enables for significant themes to emerge and then be classified into generalised categories of description. Reproduction, the movement backward and forward between theory and data, contributes to theory building based on systematic exploration of underlying methods and mechanisms. The conclusion of an inductive argument makes claims to conceptual knowledge beyond the confines of experience of the individual study. The inductive approach is an established method of research analysis in healthcare as it offers valuable insights into professionals and users’ perceptions regarding the quality and context of care and identifies barriers to changing healthcare practice.

On the other hand, deductive analysis is used when the researchers build a framework to combine different theoretical concepts, and develop hypotheses that need to be tested. According to Pope et al. (2000) “the framework approach has been developed in Britain specifically for applied or policy relevant qualitative research in which the objectives of the investigation are typically set in advance and shaped by the information requirements of the funding body (for example, a health authority). Although the framework approach reflects the original accounts and observations of the people studied (that is, “grounded” and inductive),
it starts deductively from pre-set aims and objectives” (p. 116). The hybrid approach of inductive and deductive coding and theme development in healthcare research has also been supported by Fereday and Muir-Cochrane (2008), who utilised a combination of inductive and deductive thematic analysis to decode raw data on the role of performance feedback in nursing practice, emphasising on the rigour of the process. Fereday and Muir-Cochrane’s study has important similarities with this research, as they have also gathered data from both managers and medical staff, adopting a “methodological approach which integrates data-driven codes with theory-driven ones based on the tents of social phenomenology” (p. 80).

Schutz’s (1967) social phenomenology is “a descriptive and interpretive theory of social action that explores subjective experience, (taking) the view that people living in the world of daily life are able to ascribe meaning to a situation and then make judgments” (p. Fereday and Muir-Cochrane, 2008, p. 81). Likewise, this study adopts Schutz’s (1967) social phenomenology, considering that both the medical staff and the mental health patients utilise their experiences and knowledge to decide whether they wish to participate in the service innovation process.

The method of analysis used the data-driven inductive approach of Boyatzis (1998) and the deductive a priori template of codes approach outlined by Crabtree and Miller (1999) to reach the second level of interpretive understanding. This approach complemented the research questions by allowing the tenets of social phenomenology to be integral to the process of deductive thematic analysis, while allowing for themes to emerge direct from the data using inductive coding. More specifically, the qualitative research instruments used for data collection in this study include interviews with prominent members of the case hospitals, senior medical and scientific staff, and managers. Semi-structured questions have the advantage of uncovering the interplay between different perspectives, understandings, and meanings attached to the concept of service user involvement by the various stakeholders involved in the process. However, this type of interviewing may reduce the researcher’s control over the interview situation and take a longer time to conduct and analyse, in addition to the difficulties of the analysis process. Most of qualitative researches are interview based, therefore, an outline of interview techniques and their application in medical setting is essential, explaining the rationale for these techniques and showing how they can be used in research kinds of questions.
5.1.3 Case study research design and methods

The conceptual framework developed to combine those terms in a unique perspective focused on a particular firm operating in the healthcare industry. Together with the review of innovation and entrepreneurship theories, some propositions were shaped, leading towards the research goal. The conceptual framework also provides valuable insights into the development of customer-oriented new services, identifying, at the same time, entrepreneurial opportunities. The research questions introduced in subsection 1.2 along with the conceptual framework and the propositions presented in subsection 4.3 determined the structure of the research design (Figure 5.1).

As Yin (2003, p. 19) aptly remarks “research design links the data to be collected and conclusions to be drawn to the initial questions of the study – it provides a conceptual framework and an action plan for getting from questions to set of conclusions”. In addition, Maxwell (2005, p. 33), who studied qualitative research design, states that the conceptual framework, the system of concepts, the assumptions and theories, and the methods and sampling strategy that support and inform the research, together constitute a key factor in determining the research design (Figure 5.2).
Yin supports this viewpoint, mentioning that the researcher should understand well the merits of the research prior to any field contact. He also developed a typology of case study designs, which is based on the type of case study and the unit of analysis (2014):

- Single-case (holistic) design;
- Single-case (embedded) design;
- Multiple-case (holistic) design and
- Multiple-case (embedded) design.

Furthermore, he underlines that a case study design should be adopted when:
- the focus of the study is to respond to "how" and "why" questions;
- the researcher cannot influence the behaviour of the participants;
- the researcher wishes to contain contextual conditions because it is believed that they are important to the phenomenon under study;
- the limits are unclear, between phenomenon and context.

A case study approach was approved, as the focus of the research is to respond to "what" and "how" questions. The researcher also wanted to include contextual conditions, as they appear to be important to the phenomenon under study. Additionally, a multiple-case (embedded) design was adopted, as five psychiatric hospitals were under investigation, so there were five units of analysis. Putting all these together, a qualitative type of research was undertaken, following the conception of Rohrbeck and Gemünden (2011, p. 234), who state, “for research
fields that are relatively new and about which the knowledge is limited, a qualitative research design is recommended.” This chapter describes the design of two different phases of the research. Firstly, élite in-depth interviews with the top executives of the case hospitals were conducted to identify organisations’ innovative and entrepreneurial activities as well as the role of the customer in the service development process. Elite in-depth interviews were carried out with the manager of every psychiatric hospital to discover their innovativeness: how they conceptualise and manage patient participation in every day operations as well as in new service development, and whether the hospitals adopt and implement the corporate strategy. The total number of participants for this study group was 20. Next, face-to-face semi-structured exploratory interviews with medical staff were performed to identify, for example, the crucial matter of whether they believe that patients can contribute something extra to the service innovation process or how they understand their role in promoting the internal innovation process. What is more, those interviews aim to illustrate, from the scientific point of view, how hospitals can increase customer involvement in their innovative activity and obtain a different perspective on the hospitals’ function. The total number of participants for this study group was 25, 5 interviewees from each hospital case.

Although each section of the research is independent, together they provide rich and valuable information from quite different perspectives. Information that is combined and contrasted gives answers to important questions: how patients should be involved in the service development process; how the case hospitals involve their customers in the development of their healthcare services; what medical staff perceptions of customer orientation are, and what role these perceptions play in the development of patient oriented services. Consequently, it becomes apparent that a combination of stakeholders’ views was required to gain a comprehensive understanding of the development of new, customer-oriented health services and the exploitation of business opportunities through corporate venturing. A total number of 45 interviews for all research phases were conducted during the period of November 2014 to January 2015. Below, a theoretical synopsis of the sampling and data collection process is discussed, giving emphasis on the types and style of interviews, the role of the researcher and the rationale behind the sampling and data transcription process.
Types of interviews

Accordingly, there are different types of qualitative interviews, which will be described through this study, in line with the way in which they differ from clinical consultations and the practical guidance for conducting such interviews. During their clinical work, practicing clinicians routinely interview patients. There is an issue about whether simply talking to people constitutes a legitimate form of research. However, in sociology and related subjects, interviewing is a well-established research technique that is divided into three main types, those of structured, semi-structured, and in depth interviews. The former consists of administering structured questionnaires. Interviewers are trained to ask fixed choice questions in a standardised manner. An example of fixed choice question might be if the interviewee considers his health excellent, good, fair or poor. It has to be mentioned that even though qualitative interviews are often described as being unstructured, the term "unstructured" is misleading, since no interview is completely devoid of structure as if it were, there would be no guarantee of the quality of the data. In other words, the data gathered would not have been appropriate to the research question.

Semi-structured interviews are characterised by a loose structure that consists of open-ended questions, defining the area to be explored and from which either the interviewer or interviewee may diverge to pursue an idea in more detail. In that context, continuing with the previous example, the interviewee could be asked, what he understands as good health and how he considers his health to be. Finally, in depth interviews usually cover only one or two issues, but in much detail than the semi-structured ones. Clinical and qualitative research interviews have different purposes. However, the clinical task is to fit that problem into an appropriate medical category to choose an appropriate form of management, even though the doctor may be willing to see the problem from the patient’s perspective. The constraints that are entailed to most consultations are such that being a qualitative research interview, the aim is to discover the interviewee's own framework of meanings. The research task is to avoid imposing the researcher's structures and assumptions, as they need to remain open to the possibility that the concepts and variables that result by the research might be very different from those that might have been initially expected. Additionally, the fact that any open-ended questioning needs to be brought to a conclusion by the doctor within a short
time, can be considered another constraint. An example of a qualitative research conducted by Gantley et al. (1993), who interviewed mothers of newborns in different ethnic groups to understand their child rearing practices and, by extension discover possible factors that contribute to the low incidence of sudden infant death in Asian populations. However, qualitative research can also open up different areas of research such as hospital consultants' views of their patients or General Practitioners' accounts of uncomfortable prescribing decisions.

How to conduct qualitative interviews

Researchers conducting qualitative research try to be interactive and sensitive to the language and concepts used by the interviewee. They also wish to keep the agenda flexible, aiming to understand what is underlying the surface of the topic being discussed, explore what people say in as much detail as possible, as well as to discover new areas or ideas that were not initially expected by the research. It is essential that interviewers check that they have understood respondents' meanings instead of relying on their own assumptions, taking into account that interviewees do not use medical terminology in the same way that they do, and hence, there is obvious potential for misunderstanding. Patton (1999) said that good questions in qualitative interviews should be open ended, neutral, sensitive, and clear to the interviewee, listing six types of questions that can be asked, based on knowledge, on opinion or value, behaviour or experience, on feeling, as well as those based on sensory experience and those asking about demographic or background details. Most interviewees are willing to provide the kind of information the researcher wants, however they need to be given clear guidelines about the amount of details that is required, and it is generally accepted that is best to start with questions that the interviewee can answer easily and then proceed to more difficult or sensitive topics.

The role of the interviewer

The less structured the interview, the less determined and standardised are the questions before the interview occurs. However, most qualitative researchers conducting interviews will have a list of core questions that define the areas to be covered. The order in which these questions are asked will vary, as will the questions designed to probe the interviewees'
meanings. Additionally, wordings cannot be standardised as the interviewer will try to use the person’s own vocabulary when framing supplementary questions, as well as he might introduce further questions as he/she becomes more familiar with the topic being discussed. Qualitative researchers, especially in those cases where the interviewee knows that the interviewer is also a doctor, need to consider how they are perceived by interviewees and the effects of characteristics, such as class, race, sex, and social distance on the interview. The reason becomes more intense when the interviewee is aware of the double role of the interviewer, is that he or she, as a patient or a potential one, may wish to please the doctor by giving the responses he/she thinks the doctor wants.

Due to the above, it is considered best not to interview one's own patients for research purposes, and when this cannot be avoided, patients should be given permission to say what they really think, and they should not be corrected if they say things that doctors think are wrong. Interviewers are also likely to be asked questions by interviewees during the course of an interview, which might cause problem in answering questions, as there is a potential that clinical researchers may undo earlier efforts not to impose their own concepts on the interview. However, if questions are not answered, the interviewee’s willingness to answer the interviewer’s subsequent questions might be reduced. One solution to the above is to say that any questions will be answered at the end of the interview, although this is not always a satisfactory response. Qualitative interviews also require considerable skill on the part of the interviewer. Even though experienced doctors may feel they already possess the necessary skills, it is essential to achieve the transition from consultation to research interview, where clinical researchers need to monitor their own interviewing technique, critically assess tape recordings of their interviews and asking others for their comments. The research interviewer needs to evaluate how directive he/she is being, whether leading questions are being asked, whether cues are picked up or ignored, as well as whether interviewees are given enough time to explain what they mean. Due to the vitality of maintaining control, Patton (1987) provided three strategies, including knowing the purpose of the interview, asking the right questions to get the information needed as well as giving appropriate both verbal and non-verbal feedback. As in most cases, there are drawbacks that are related to some common pitfalls for interviewers. Morse and Field (1996) have identified consequences, as outside interruptions, competing distractions, stage fright, awkward questions, jumping from one subject to
another, and the temptation to counsel interviewees. However, awareness of these pitfalls can help the interviewer to develop ways of overcoming them.

**Keeping record**

There are various ways of recording qualitative interviews, such as notes written during the interview or afterwards, as well as audiotaping. When it comes to the former, it can interfere with the process of interviewing, while the second is likely to miss out some details. Consequently, even though written notes are preferable to audiotaping, a tape-recorded interview eliminates the above drawbacks, although it may take both parties a little while to speak freely in front of a machine. In that context, it is essential to use good quality equipment which has been prior-tested and with which the interviewer is familiar. In the downturns, it should be noted that transcription is a time consuming process, as each hour’s worth of interview can take six or seven hours to transcribe, depending on the quality of the tape, which requires the costing of any interview based study to include adequate transcription time.

**Sampling strategy**

The process of identifying interviewees is determined by the purpose of the research project. Statistical representativeness is not normally sought in qualitative research, while sample sizes are not determined by hard and fast rules. On the contrary, they are based on factors such as the depth and duration of the interview and what is feasible for a single interviewer. Large qualitative studies do not often interview more than 50 or 60 people, although there are exceptions. Unlike clinicians conducting research in their own workplace, sociologists conducting research in medical settings often have to negotiate access with great care. Nevertheless, in any case, the researcher needs to approach the potential interviewee, and present the purpose of the research, explaining that a refusal will not affect future treatment. For the same purpose, an introductory letter should be handed to the potential interviewees, describing what is involved, the expected duration of the interview, clarifying that they will be conducted at interviewee s' convenience and should give assurances about confidentiality. Finally, it is usually preferable to interview people at home if take into account that the setting of an interview affects the content.
Data transcription

Transcripts of the above interviews were coded ‘horizontally’ into major theme categories. This strategy allows for the documentation of relationships between emerging themes as well as similarities and differences across sub-groups (e.g. service providers vs. individuals, medical professionals vs. the board of directors). The kind of understanding gained through this strategy uncovers the complexity of conflicting attitudes, values, and beliefs towards user inclusion in the context of changing practice in the mental healthcare sector. This kind of understanding emerges through the construction of major themes or categories from the raw data. Findings are the result of setting the research objectives on the outset of the research project and arise directly from the interpretation of the raw data. Inevitably, these findings are claimed to be shaped by the assumptions and experiences of the researcher who makes the decision of what is more or less important in the data. The credibility of these findings is tested against the feedback from previous research.

The conclusions resulting from the coding have the following key features. They are labelled according to their inherent meanings or specific features of the category in which they fall. This classification presupposes a detailed descriptive and evaluative account of the characteristics, scope, and limitations of each of the emerging categories. Examples of text coded are provided to further exemplify and illustrate meanings, associations, and perspectives associated with each category. Causal links between different categories or other major themes are established in a hierarchical category system, which assume commonalities or differences between categories or other causal relationships. Generalisation of assumptions or categories provides the potential to incorporate research findings into a wider theory or framework.

Rationale for employing face-to-face in-depth interviewing

The effectiveness, validity, and reliability of the research depend on the appropriate selection of research methods and techniques. After considering the application of each qualitative technique, in-depth interviews were considered appropriate for this study. Firstly, the in-depth interview technique uses open-ended questions that allow the interviewees to provide broader ideas. The researcher has more scope to understand the perceptions and attitudes of
different respondents. In addition, the researcher can deal with the complexities, probe deeper for more important information, or even control over the rate of missing data. To achieve the objectives of data collection, the researcher can assist respondents during face-to-face in-depth interviewing (Seidman, 2012; Robson, 2002). In addition, other data collection techniques, such as collage and word association, can be used to facilitate the interview (Bernard, 2000). The researcher can also judge the extent to which the interviewing is treated seriously (Robson, 2002). Indeed, face-to-face in-depth interviews have the highest response rate and permit for the longest interview period (Irvine, 2011; Saunders et al., 2011). Advantages or disadvantages of the in-depth interviewing are presented in Table 5.1.

Elite interviewing is one of the least widely referred to research methods in business studies. As it is mentioned above, elite face-to-face interviews provide breadth and depth of information about the background context of a research effort that may not be feasible through other kinds of interviews (Moore and Stokes, 2012). The major difficulty in elite interviewing lies in gaining access to an expert population and the limited time allowed for the interviews. Other techniques in Table 5.1 were not selected. The focus group technique is advantageous as it has all experts in the same discussion table brainstorm each question. However, it would have been hard to ensure the simultaneous availability of all these top executives and hospital managers. In addition, some answers cannot be disclosed to the public, as they may reveal classified information. The observation technique is commonly used in behavioural studies as well as the other qualitative techniques, such as word association, sentence completion, and collages, can be used as facilitation tools in in-depth interviews or the focus group (Table 5.1). However, the researcher decided not to use these tools, as the questions in the interview guide were deemed sufficient. It was concluded then that the in-depth interviews and the questions in the interview guide were appropriate for all the three sections of the study.

<table>
<thead>
<tr>
<th>Techniques</th>
<th>Description</th>
<th>$a$</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-depth Interviews</td>
<td>This technique is the interview between a researcher and a respondent. The researcher asks the questions listed on the interview guide and follows up with probes to get more information.</td>
<td>The respondent can give their opinion and is not interfered by others. Having more time to respond to specific topics. Can use with a sensitive topic.</td>
<td>Success of the interview depends on the skill of the researcher. Cannot generalise to the population. A very expensive technique.</td>
<td></td>
</tr>
</tbody>
</table>
Observation

The researcher observes an event and makes a record. With the ethnography technique, the researcher participates in the interested activity and asks questions at that time.

Observing hidden behaviour that cannot be uncovered by other techniques. Can observe the person or event continuously.

Cannot observe in some private places. When people know about the observation, they will act unnaturally. Can be a very expensive technique.

| Semi-Structured Interviews | Specific open-ended questions divided into sections are in the written form. The respondent can describe as they want. | Can describe specific issues. Easy to analyse research results | As the questions are set up, the interview lacks flexibility |
| Focus Group Interviews | An unstructured interview with a group of six to ten participants. The well-trained moderator uses a discussion guide to lead the focus group and encourages the participants to share ideas. | The combined effort of the group. Can clarify the participants’ ideas. Obtaining new ideas for the snowballing effect (the chain of responses) | Hard to recruit all experts to stay in the same place at the same time. Cannot generalise to the population. Sensitive topics cannot be discussed. An expensive technique |
| Word Association/Sentence Completion | First word or sentence that comes to mind in response to an interesting topic, such as a brand. | The answer is quite true as the first thing that comes to mind. Take short time | Cannot get many details from this technique. Cannot probe for more details |
| Collages | The respondent can express their thoughts by assembling the pictures. The researcher can prepare these pictures from different magazines. | Collecting more details from the stories in the pictures | Dependent on prepared materials and interpretation of the researcher |
| Thematic Apperception | The respondent tells the story of an ambiguous picture. | Flexible response. Can uncover a sensitive issue. | Dependent on the interpretation of the researcher |

Note: Modified from the table of common qualitative research tools by Zikmund and Babin (2007)

5.1.4 The value and benefits of case study research

There are a rather large number of definitions of the term “case study.” Merriam-Webster’s dictionary (2011) defines a case study as, “an intensive analysis of an individual unit (as a person or community) stressing developmental factors in relation to environment.” Likewise, Simons (2009, p. 21) described case study as “an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, program or system in a ‘real life’ context.” Thomas argued (2011, p. 513) that “case studies are analyses of persons, events, decisions, periods, projects, policies, institutions, or other systems that are studied holistically by one or more methods. The case that is the subject of the inquiry will be an instance of a class of phenomena that provides an analytical frame - an object - within which the study is conducted and which the case illuminates and explicates”.

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According to Eisenhardt (1989), case study is a strategy to investigate the dynamics shown in a particular subject. Usually, case studies are used to provide description, to examine, or to build theory (Schiele and Krummaker, 2011; Marschan-Piekkari and Welch, 2011). Case study is an adequate method for some important goals of research in social sciences, and essential for the development of social sciences, for example, understanding the extent to which certain phenomena exist in a particular group or how they differ between cases (Flyvbjerg, 2006). The case study approach has the dynamics to address complexities and is an excellent method of obtaining a comprehensive picture of the case. It also allows the researcher to collect data from various sources and compare them to elucidate the case (Baxter and Jack, 2008). Additionally, Eisenhardt’s study (1989) identified that case studies may combine information between cases, data types, and different researchers, Case studies may increase the likelihood of creative redesign, between cases and literature, in a new theoretical vision. Her research also noted that novel theory is generated by case studies and is empirically valid as it results from the link with empirical evidence. Theories developed by case studies are particularly suitable for new research fields or fields for which the offered theory appears poor (McLeod and Elliott, 2011).

Furthermore, theory production from case studies is a research strategy, which engages one or more cases to establish theoretical structures and propositions from case-based empirical data (Yin, 2011; Eisenhardt, 1989). Reliable empirical research is initiated with in-depth investigation of relevant literature, identifies research gaps, and submits research questions to deal with those gaps (Eisenhardt and Graebner, 2007). In particular, the studies by Yin (2014) and Stake (1995) distinguish case studies of various forms. For example, Yin classified explanatory, exploratory, or descriptive case studies, while Stake categorised them as intrinsic, instrumental or collective. Swanborn (2010, p. 77) notes, nevertheless, “most designs are mixed because research questions of divergent character are to be answered (e.g. exploratory and descriptive questions or exploratory and explanatory questions). Overall, the same theory can be used for different purposes”. The present study utilises both exploratory and explanatory research, as the former enhances the investigation of the case hospitals’ aims, while the latter clarifies the organisations’ attributes and customers’ condition. Yin (2010, p. 98) clearly recognises in his book that “most studies can derive greater value if their findings and conclusions have implications going beyond the data collected - that is, the extent
to which the findings can be ‘generalized’ to other studies and other situations... This is true even where a study might have only a single data collection unit, such as a single case study.” Therefore, “case study, like the experiment, does not represent a ‘sample’, and in doing a case study, your goal will be to expand and generalize theories (analytic generalization) and not to enumerate frequencies (statistical generalization)” (Yin, 2014, p 15). Baxter and Jack (2008, p. 544), who carried out research to help researchers identify the key elements for planning and applying qualitative case study research projects, put it like this: “when the approach (qualitative case study) is applied correctly, it becomes a valuable method for health science research to develop theory, evaluate programs, and develop interventions”. However, they also report that the general aim of the research determines the preference for a certain type of case study design.

This research study exploits the theory and research context to develop a research design framework that directs the data collection process, followed by the comparison of the findings with relevant literature to raise external validity. Apart from exploratory interviews, other techniques of data gathering were also used in this research. As the researcher is linked to the healthcare sector of Northern Greece, particularly to the case hospitals, he had the opportunity, for example, to interact with the medical staff and have a physical presence in hospitals’ facilities. This increased the construct validity of the research, as the researcher was in a position directly to assess the responses of the interviewees. The importance of face-to-face interviews and observation of respondents is highlighted by Yin (2014). Finally, it becomes apparent that a cross-case analysis could also be carried out (see Chapter 7) to gather the findings across the case-study hospitals and the mother corporation. This enables cross-case conclusions to be drawn, strengthening the findings, and allowing more valid generalisation of evidence to provide a wider picture.

5.2 Exploratory field study

Research phase 1 aims to investigate issues regarding innovation, entrepreneurship and customer orientation from the management perspective. All things considered, “the role and responsibility of top management is to deliberately create processes (regarding innovation and corporate entrepreneurship) that are carefully cultivated and maintained through cultural
and structural design” (Kemelgor, 2002, p. 70). Similarly, research phase 2 aims to examine issues relating to user participation in service development and delivery from the medical point of view.

5.2.1 Research objectives and questions

The administration and strategy-related side of the research reveals the viewpoints of the executives and higher-level managers of the case hospitals as regards their innovative and entrepreneurial activities and how they take in the participation of patients in the new service development process. As was stated in subsection 1.2, the research questions for Phase 1 are:

- **RQ1** - Where, how and why should patients be involved in new service development?

- **RQ4** - How and to what extent is corporate venturing developed by adopting service innovation initiatives?

These research questions originated from the emerging arguments in service innovation and entrepreneurship literature. In particular, the first question derived from discussion and scientific analyses on customer involvement in the development of new healthcare offerings, while the latter came from theories about entrepreneurship and innovation (see Chapters 2 and 4). The propositions developed for this Section (See Chapter 4.4) were based on the theories of both innovation and corporate entrepreneurship and service development and customer orientation. The propositions were developed in line with the above research questions concerning the business development study. The propositions and the research questions above aimed to explore, on one hand the role of customer in service development, and on the other, how the case organisation exploits these innovations to expand its operations. This connection is illustrated in Figure 5.3.
On the other hand, the medical staff related side of the research uncovers the position and opinions of doctors, psychologists, occupational therapists and others in the mental health hospitals with regard to mental patient involvement and new service development. Additionally, the perspective of their role in promoting an internal innovation process is explored. Following the research questions of the research phase 1, phase 2 includes:

**RQ2 - How do medical personnel perceive patient involvement in new service development?**

**RQ3 - What is the role of medical personnel in patient-oriented service development?**

This research question derived from the growing debate in the relevant literature about the role of medical staff in patient-oriented new service development (see Chapter 2). It also determined the research method selected for Phase 2. The results of this Phase, together with the review of the relevant literature, added to the development of the conceptual framework (See Chapter 4.3). The stages of the research process for this Phase are shown below (Figure 5.4).
Overall, this study explores the entrepreneurial dynamics as well as the level of patient involvement in service innovation development. By interviewing hospitals’ executives and medical personnel, the researcher was able to gain a thorough understanding of the aforementioned challenges, which, along with the exploration of theory, led him to produce an advanced research outcome on regional health service innovation. In particular, the primary data was used to develop an understanding of the entrepreneurial dynamics and patient involvement in service innovation. This study also identified relationships at the case level as well as across the different cases presented throughout the research. The use of several case studies also led to highlight underlying schemes and rationales across the cases. It is acknowledged by previous academics that the use of multiple cases is grounded in a replication logic that allows comparing, contrasting, and extending the newly developed theory (Eisenhardt and Graebner, 2007). This argument is inherent to the fact that entrepreneurial dynamics do not follow pre-defined patterns and hence may come in different varieties because they arise from combinations of internal dynamics. Hence, a comparative case study approach is seen here as beneficial to understand the evolving dynamics of entrepreneurship and customer involvement in knowledge-intensive service organizations, such as those in mental health care. A key step in the research was to collect primary data that enabled the researcher to identify and understand comparative differences and commonalities in the emergence of customer-driven innovation as well as to investigate the ways by which they support and enrich entrepreneurial activities.

5.2.2 Data collection

In-depth élite interviewing was adopted as the primary data collection method for research phase 1 due to the nature of the research purpose. This technique provides a deep and rich investigation of executive viewpoints regarding entrepreneurial activities and the development of customer-oriented services. Elite interviewing is not a common research technique and has not been broadly mentioned in the business literature on in-depth interviews (Moore and Stokes, 2012; Ozdemir, 2007). Elite interviews, though, offer valid and reliable data on the central questions of this research project. Richards’s study (1996) reports that the élite interview process assists the researcher in appreciating the perceptions and values of the interviewee; essentials that cannot be found in documents or records, but which
influence decision-making. Another study by Goldstein (2002) suggests that researchers should adopt élite interviewing to seek information from a specific sample of officials (élites) to generalise the outcome in connection with their characteristics or to search for particular information. Therefore, researchers should be well-prepared, ask the proper questions, establish a close relationship with participants, and work up the responses accurately and consistently to make the analysis process straightforward and minimise the inaccuracy contained in any interview data. What is more, researchers should be receptive to the prospect that élite interviewees might have different professional values, seniority, gender concepts, or culture. A study by Welch et al. (2002a) recommends that researchers seek balance in the interview process, exploiting this opportunity to enhance communication and information exchange (Figure 5.5).

Figure 5.5 Balancing act by the researcher in an élite interview (source: Welch et al., 2002a)

But how élites are defined? Giddens (1972) first described élites as a group of people consisting of top executives of the organisation. More recently, a study by Hornby et al. (2005, p. 495) indicated élites as “a group of people in a society, etc. who are powerful and have a lot of influence, because they are rich, intelligent, etc.” Likewise, Richards (1996, p. 199) define élites as “a group of individuals, who hold, or have held a privileged position in society and as such, (...) are likely to have had more influence on political outcomes than general members of the public”. On the other hand Welch et al. (2002b, p. 613) characterise the élite interviewee in international business as “an informant (usually male) who occupies a senior or middle management position; has functional responsibility in an area which enjoys high status in accordance with corporate values; has considerable industry experience and frequently also long tenure with the company; possesses a broad network of personal relationships; and has considerable international exposure”. Nevertheless, there are
considerable difficulties in accessing élites. Hertz and Imber’s study (1993, p. 3) argues, “(élites) establish barriers that set their members apart from the rest of society.” Hence, the interview process is time-consuming and costly. In the case of the present research, the researcher mainly used personal connections and institutional affiliation to gain access to people and data. In addition, the issue of openness is critical, as participants need to share their opinions, beliefs and thoughts, without the constriction of having to answer in line with stated organisational policies (Welch et al., 2002; Tansey, 2007). This researcher found that medical staff or those who are in middle management positions were defensive in their answers, while higher executives were more open in their reports. Many studies have mentioned this, stating that data are more reliable and accurate when derived from high status business informants (e.g. Macdonald and Hellgren, 2004; Fitz and Halpin, 1995).

Similarly, an exploratory type of research was agreed on, to investigate whether medical staff believe and share the view that patients should actively participate in treatment and services provided and to determine whether each hospital employs the necessary procedures and tools to forward such projects. An expert judgement technique (Smith and Fischbacher, 2005) was approved to opt for informants who are considered able to provide insight as regards the particular behaviours and processes that are being studied. Similarly to the data collection method applied in research phase 1, interview questions lasted between 25 and 30 minutes and were recorded and transcribed.

Overall, data collection for this thesis was not a difficult process, though time-consuming. The researcher had conducted initial, informal discussions with the CEOs and Scientific Directors of the case hospitals, describing and analysing the purpose and objectives of this study. Following these discussions, in which the researcher received verbal consents to involve these organisations in his study, he organised exploratory, unofficial visits to the premises of the case hospitals, before the interview process begins, in an effort to meet with and introduce himself to the potential interviewees at a mutually convenient time, and present and discuss the purpose of the research. The administrators of the case hospitals have been the contact points for the researcher. He arranged the above visits with the administrators, requesting permissions of the executives to conduct the visits, providing enough time in advance to potential participants to be informed. For the same purposes, an
introductory letter was handed to them, describing the type, purpose and objectives of the study and interviews, the expected duration of the interview, the methods to contact the researcher after the interview process completes, clarifying that they would be conducted at interviewees’ convenience and should give assurances about confidentiality. A week after those exploratory visits, the researcher followed up to see how many of the potential interviewees were willing to participate in the study. Following this step, a schedule of the visits for interviews was developed with the administrators. The interviews were carried out at the hospitals’ premises, were tape-recorded for future analysis and assessment, and lasted 60 to 70 minutes.

5.2.3 Questionnaire design

The interview questions derived from the innovation-management, entrepreneurship, and customer-orientation reviews of the literature and were prepared for the analysis of both the new patient-oriented services development and the ways these new services might aid the case psychiatric hospitals with establishment and growth in the sector of mental healthcare. It was also essential to conclude whether the hospitals have their own procedures and tools to support such projects. The questions covered topics related to: the role of administrative and medical staff in innovation activity, the level, and type of market research undertaken on user- oriented service development, and the management practices engaged when developing new services. The key questions developed for discussion were about:

- The factors that condition or stimulate mental health hospitals towards innovation;
- The tools and processes used to generate opportunities for service development;
- The culture and the incentives for staff to identify and act on opportunities for improvement;
- The role of top executives in promoting the internal innovation process;
- The stimulus of growth and how this could help the hospitals to become more innovative, developing new services and approaching new markets;
- The organisation and the structure of the case hospitals to implement innovative actions;
- The number of services developed in the recent past and the plan for the extension and evolution of their services;
- The coordination among people and departments throughout the new service development process;
- Venturing and entrepreneurial activity in the case hospitals and their venturing objectives;
- The encouragement and support of entrepreneurial activity and rewarding of innovative efforts;
- The level of market assessment and the type of information obtained before any investment is undertaken;
- The level of cooperation between departments to discuss market trends and developments;
- The nature of the relationship between the case hospitals and their customers;
- How the hospitals respond to customer queries and complaints and whether these are integrated into the service planning process;
- Whether there is room for customisation and judgement on the part of a service provider;
- The enhancement of customer involvement in hospitals’ innovative activity, and
- Whether there are measures of customer satisfaction that the organisations use to improve its services.

Studies by Ozuru et al. (2013), and Aberbach and Rockman (2002) stress that the open-ended questions method is an outstanding approach to employ in cases where a researcher needs to search for information and offer interviewees flexibility in shaping their responses. Likewise, semi-structured interview questions might explore the key issues mentioned above. This research instrument included some of the same questions used in the interviews with hospitals’ administrative staff. The aim of this action was to collect a similar kind of information, but from different perspectives - that of administrative and medical staff – to make comparisons (see Table 5.2, and Appendix 2). Questions mainly linked patient contribution to new service offerings, the hospital climate regarding innovation activities, and the role of medical staff in the hospital’s innovation practice.

In this study, the case organisations are regarded as dynamic units, and subject to a process of transformation and changes. They can be born, grow or disappear in response to
internal and external changes. The process of growth and the development of new services are highly conditioned by the efforts of entrepreneurs as well as the systematic accumulation of knowledge and manpower skills. Therefore, basic characteristics of the firms under study, including information concerning both pre- and post-production, should be taken into account before empirical analysis can be made. In this context, the first part of this list of questions concerns innovation activity, culture, and structure of the case organisations. These questions aim at providing descriptions of the motivation and organisation for new service development. The second part explores new service activity within the case hospitals. The third part, of semi-structured questions, hopes to illuminate the entrepreneurial model that the organisations follow, along with how entrepreneurial opportunities are identified and selected. Finally, the last part sets out to discover the role of market assessment and customer involvement in the organisations’ new service development strategy (see Appendices 1 and 2, and Table 5.2).

Table 5.2 Measurement Items for both research phases

<table>
<thead>
<tr>
<th>Subjects to be measured</th>
<th>Questions</th>
<th>Sources</th>
</tr>
</thead>
</table>
| **INNOVATION**  
Activity, factors, and  
business culture | 1. What are the internal factors that predispose the organisation to seek access to innovation?  
| | 4. Does the organisation do enough to create:  
i) A culture where continuous improvement is regarded as a norm?  
| | 5. How adequately or appropriately are the requirements of customers taken into account in the organisation’s innovation strategy? | Korschun et al. (2014), Witkowska and Lakstutiene (2014), Feng et al. (2012), Mahr and Lievens (2012), Blocker et al. (2011), De Faria |

Interview questions that target to explore the opinion of the medical personnel are noted in italics.
<p>| | |</p>
<table>
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<tbody>
<tr>
<td><strong>NEW SERVICE DEVELOPMENT</strong>&lt;br&gt;Process, service improvement and evolution, and coordination</td>
<td></td>
</tr>
<tr>
<td><strong>6.</strong> Do you believe that customers can contribute something extra to the service innovation process?</td>
<td>Grissemann et al. (2013), Hillebrand et al. (2011), Hoyer et al. (2010), Agarwal and Selen (2009), Alam (2002), Alam and Perry (2002)</td>
</tr>
<tr>
<td><strong>7.</strong> What do you think is the role of the top executives/medical staff in promoting the internal innovation process?</td>
<td>Garrett and Neubaum (2013), Mainela (2012), Zhou et al. (2012), Sebora and Theerapatvong (2010)</td>
</tr>
<tr>
<td><strong>8.</strong> Do you believe that the stimulus of growth could help you become more innovative, developing new services and approaching new markets, and why?</td>
<td>Bock et al. (2012), De Burcharth and Ulhøi (2011), Yarbrough et al. (2011), Hartzband and Groopman (2009)</td>
</tr>
<tr>
<td><strong>9.</strong> Do you believe that the organisation and the structure of the organisation help you to implement innovative actions? If so, how does this happening?</td>
<td>Efrat (2014), Naranjo-Valencia et al. (2011), Hartzband and Groopman (2009), Avlonitis et al. (2001)</td>
</tr>
<tr>
<td><strong>12.</strong> How and to what extent has your service products changed during the past 2 years?</td>
<td>Fox et al. (2014), Hidalgo and D’Alvano (2014), Kindström et al. (2013), Sigala (2012a; 2012b), Jiménez-Zarco et al. (2011), Varadarajan (2009)</td>
</tr>
<tr>
<td><strong>13.</strong> Does the organisation have a plan for the extension and evolution of its services?</td>
<td>Carlberg et al. (2014), Ndubisi (2014), Bettencourt et al. (2013), Cheng et al. (2012), Hsieh and Hsieh (2012), Gustafsson et al. (2012)</td>
</tr>
<tr>
<td><strong>14.</strong> Where did the concept of developing new services come from? (existing customers, new customers, market research, always part of the plan?)</td>
<td>Rapaccini et al. (2013), Santos and Spring (2013), Krishna and Kautish (2012), Belkahlia and Triki (2011), Cambra-Fierro et al. (2011), Storey and Hull (2010), Loch and Kavadias (2008)</td>
</tr>
<tr>
<td><strong>15.</strong> How would you evaluate the coordination among people and departments throughout the new service development process?</td>
<td>Evald and Senderovitz (2013), Mainela (2012), De Faria et al. (2010), Stevens and Dimitriadis (2005)</td>
</tr>
<tr>
<td>CORPORATE ENTREPRENEURSHIP</td>
<td>CUSTOMER ORIENTATION</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Business model, venturing activities, entrepreneurial opportunities</td>
<td>Market assessment, customer relationships and involvement, service customisation, customer satisfaction</td>
</tr>
<tr>
<td><strong>16.</strong> Will you please describe the venturing and entrepreneurial activity in the organisation?</td>
<td>Titus et al. (2014), Battistini et al. (2013), Baum et al. (2013), McGrath et al. (2012), Narayanan et al. (2008)</td>
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<tr>
<td><strong>17.</strong> What are the organisation’s venturing objectives?</td>
<td>Evald and Senderovitz (2013), Lin and Lee (2011), Narayanan et al. (2008), Henderson and Leleux (2005)</td>
</tr>
<tr>
<td><strong>20.</strong> What preliminary market assessments occurred before any investment was undertaken? (market research, market segmentation)</td>
<td>Bowers and Khorakian (2014), Brem and Borchardt (2014), Alegre et al. (2013), Grissemann et al. (2013), Lee et al. (2011), Jaw (2010)</td>
</tr>
<tr>
<td><strong>22.</strong> How much time and effort is spent in conducting interdepartmental meetings to discuss market trends and developments?</td>
<td>Autio et al. (2014), Bowers and Khorakian (2014), Audretsch et al. (2013), Audretsch and Link (2012), Duncan and Breslin (2009)</td>
</tr>
<tr>
<td><strong>23.</strong> What type of relationship does the organisation have with its customers?</td>
<td>Korschun et al. (2014), Hillebrand et al. (2011), Ernst et al. (2010), Grönroos (2007)</td>
</tr>
<tr>
<td><strong>24.</strong> Is there an adequate process to track and respond to customer queries and complaints? If so, does management get an up to date of the status of complaints?</td>
<td>Mahr et al. (2014), Feng et al. (2012), Carbonell et al. (2011), Duarte (2010), Alam (2002)</td>
</tr>
<tr>
<td><strong>26.</strong> How much room is there for customisation and judgement on the part of service provider?</td>
<td>Witkowska and Lakstutiene (2014), Homburg et al. (2011), Hoyer et al. (2010),</td>
</tr>
</tbody>
</table>
27. Please determine the ways by which the hospital can increase customer involvement in its innovative activity.


28. Are there measures of customer satisfaction that you use to improve your services?

Avise et al. (2014), Groene et al. (2014), O’Brien et al. (2013), Thompson and McCabe (2012), Cheung and To (2011), Svendsen et al. (2011)

Feng et al. (2012), Tajeddini (2011), Tajeddini (2010), Dong et al. (2008)

Regarding the background information of each firm, the majority of the measures used to assess the general background in Questions 1 and 2 were developed by adopting ‘firm related external and internal factors’ as suggested by Van Der Panne et al. (2003). Van Der Panne et al.’s (2003) study, suggests ‘firm related factors’ are one of the four categories included in a classification of factors that affect the innovativeness of an organisation. Subsequently, this might depend on the satisfaction of relevant factors concerning the firm’s background as well as the ecosystem that operates in. Question 3 investigated whether the company uses adequate tools and processes to generate opportunities for product development as suggested by Ali (1994) and Ali et al. (1995). These two studies report that the proper tools and processes lead to the creation of opportunities for product development. Question 4 attempted to examine whether there is a business culture that promotes innovation and acts on opportunities for improvement as pointed out by many studies: Wei et al. (2014), Evald and Senderovitz (2013), Naranjo-Valencia et al. (2011), Yarbrough et al. (2011). Question 5 aims to investigate whether the case organisation takes customer requirements into consideration to develop its innovation strategy. Several studies (e.g. Cheng, Chen, et al., 2014; Jean et al., 2014; Grissemann et al., 2013; Carbonell et al., 2012; Edvardsson et al., 2012; Blocker et al., 2011; Alam, 2006, 2003, 2002) have argued that customers’ needs should be considered as key factors for innovation development. Similarly, Question 6 aims to explore whether the executives in question consider customers as key players of the innovation process, as Korschun et al. (2014), Agarwal and Selen (2009), Alam (2002), and Alam and Perry (2002) have pointed out. In addition, Question 7 helps the researcher to understand how executives perceive themselves in the promotion of the innovation process as emphasised by Alvarez et al. (2013), Becker and Egger (2013), Belousova and Gailly (2013), and so on. Question 8 adopts the arguments of Anderson and Eshima (2013), Autio et al. (2014), Boso et al. (2012) that the stimulus of growth guides companies to become innovative and
entrepreneurial, therefore, it aims to investigate whether executives appreciate it as such factor. Questions 9 and 10 aim to explore whether the case hospitals have developed such structure and organisation that enable the implementation of innovative actions and whether this has led to the development or improvement of services. Several studies (e.g. Lin and Huang, 2012; Kelley, 2011; Adner and Kapoor, 2010; Eisingerich et al., 2009) have noted that proper organisation and structure is required for innovation development, particularly in the mental health sector.

The second part of the questionnaire aims to explore the new service development activity and process of the case hospitals. Questions 11, 12, and 13 aim to show whether the case organisations have developed and/or improved their services the recent years as well as whether there is a plan for the extension and evolution of its offerings. According to Gremyr et al. (2014), Edvardsson et al. (2013), Cheng and Krumwiede (2012), and others (e.g. Carbonell et al., 2012; Gao and Chen, 2010; Jaw et al., 2010; Jin et al., 2010), those kind of questions give a good picture of the innovation activity of a firm. Likewise, Question 14 aims to explore the source of the main ideas for new services, as this is measurement tool of firms’ innovativeness as pointed out by Storey and Hull (2010), Ernst et al. (2010), and Sebora and Theerapatvong (2010). Finally, Question 15 investigates the level and quality of cooperation for service innovation among different parties within the organisation. According to Hidalgo and D’Alvano (2014), Jiménez-Zarco et al. (2011), De Faria et al. (2010), and Stevens and Dimitriadis (2005), productive cooperation between people and departments has a positive impact on the new service development process. Following the second part, Questions 16 and 17 aims to examine the venturing objectives and entrepreneurial activities of the case hospitals, as this would show whether there is a linkage between service innovation and the entrepreneurial initiatives of the firms (e.g. Ravix, 2014; Belz, 2013; Mars, 2013; Onetti et al., 2012; Soriano and Huarrng, 2013). Similarly, Questions 18 and 19 explore how entrepreneurial opportunities are identified and evaluated by the case hospitals and examine the ways by which they encourage, support, and reward such initiatives. Many studies have shown that the evaluation process of business expansion opportunities influences also the innovation activity of a firm as well as employees’ quality of the contribution (e.g. Cavusgil and Knight, 2015; Autio et al., 2014; Brem and Borchardt, 2014; Alvarez et al., 2013; Anderson and Eshima, 2013; Boso et al., 2012; Covin and Lumpkin, 2011).
The last section of the questionnaire investigates the level of customer orientation at the case organisations. Questions 20 and 21 continue the goal of previous questions, aiming to explore whether the case hospitals gain knowledge and inputs from the market as well as how they assess the opportunities before any investments take place. According to many authors, the information and initial assessment of any type of innovation is required and determines the success of the effort (e.g. Bao et al., 2012; Boso et al., 2012; Cheng and Krumwiede, 2012; Cambra-Fierro et al., 2011; Durmuşoğlu and Barczak, 2011; Jiménez-Zarco et al., 2011). Similar to Question 15, Question 22 aims to examine the amount of time and effort that is spent in interdepartmental meetings regarding market trends and developments. Several studies have pointed out that such activities are critical for the development of offerings that will meet market needs (e.g. Hidalgo and D'Alvano, 2014; Lado and Maydeo-Olivares, 2001). Moreover, Question 23 explores the type of relationship between the case organisation and its customers, because studies have proved that the good relationship between the two parties influences positively the development and promotion of innovations (e.g. Black et al., 2014; Anderson and Eshima, 2013; Ernst et al., 2010). Questions 24 to 27 aim to investigate whether a process, and/or a formal method and/or a mechanism is used by the firms to respond to customer queries and incorporate them into the service planning process, increasing customer involvement in its innovative activity. Many authors have argued about the importance of such tools and procedures that track complaints as well as integrate customer views into the innovation process (e.g. Chen et al., 2014; Brockhoff, 2013; Carbonell et al., 2011; Cheung and To, 2011; Svendsen et al., 2011; Piller et al., 2010). Finally, Question 28 explores whether there is flexibility on the part of the service provider, as several studies have pointed out the importance of customisation in the service offerings, especially in the mental health sector (e.g. Lewis, 2014; Ennis and Wykes, 2013; Newton et al., 2013; Giotakos et al., 2010; Gao and Chen, 2010; Borg et al., 2009).

Validation process of the questionnaires with the item objective congruence (IOC) index

The validation of the questionnaire was completed using the IOC technique and pilot tests. There were two main stages performed [adapted from Weir (2005)] to validate the questionnaire as presented in Table 5.3 below. During the validation process, the IOC index was 0.85. The first draft of the questionnaire (40 questions) was revised, and twelve questions
were finally rejected. After the completion of the two stages in the quality control process in Table 5.3, the English version of the complete questionnaire was completed as shown in Appendix 1.1 (the Greek version of the questionnaire is presented in Appendix 1.2).

Table 5.3 Stages in the quality control process of the survey instruments

<table>
<thead>
<tr>
<th>Stage 1: A Priory Validation</th>
<th>Stage 2: A Posteriori Validation</th>
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</thead>
<tbody>
<tr>
<td>Test Specifications of the Constructs</td>
<td>Literature Review</td>
</tr>
<tr>
<td>Literature Review</td>
<td>Needs Analysis (based on the reviews)</td>
</tr>
<tr>
<td>First Draft</td>
<td>Items Setting</td>
</tr>
<tr>
<td>Literature Review</td>
<td>Small Piloting (1&lt;sup&gt;st&lt;/sup&gt;)</td>
</tr>
<tr>
<td>Needs Analysis (based on the reviews)</td>
<td>IOC index (experts’ judgement for content and construct validity)</td>
</tr>
<tr>
<td>Pilot Study</td>
<td>Estimating Reliability</td>
</tr>
<tr>
<td>Main Study</td>
<td>Obtaining Experts’ Judgement</td>
</tr>
<tr>
<td>Main Study (Conducting Interviews)</td>
<td>Revising the Instrument</td>
</tr>
<tr>
<td>Process of Administration</td>
<td>Obtaining the Results</td>
</tr>
</tbody>
</table>

Improvement and completion of the questionnaires following the validation and ethics review processes

The validation process above helped the researcher to identify the key questions that would delve into the examined concepts, exploring the participants’ opinions, which illustrate the actual picture of the mental health services provision within the healthcare industry in Greece along with the techniques that should be adopted to develop and implement customised offerings. It is worth mentioning that the phraseology of the questionnaire was adopted, following the suggestions of those who participated in the pilot testing process. Some participants in pilot testing expressed concerns as to the clarification of the questions. For instance, few participants asked the researcher to revise the wording of some questions (i.e., 6, 8, 14, 18, 21, 27) so that they can be clear and understandable. Given (2015, p. 23) reports in her book, “once in the field, researchers will find that the wording of specific questions, the specific micro-topics discussed...may change, depending on what is learned at the early stages of data collection and analysis.”

In addition to the validation process, the researcher requested from the Research Ethics Committee of the University of Portsmouth to review and assess the proposed research methodology to ensure that it entails no risk for the participants. The committee provided the
researcher with comments regarding the wording of the scientific and technical content of the research instrument. The comments of the Research Ethics Committee were taken into consideration so as to improve the data collection process. For instance, the committee asked the researcher to describe in detail how the participants were recruited and selected as well as included some suggestions as to the wording and phraseology used in the research instrument. Both the committee and the researcher wished to ensure that the research instrument would be understandable by all potential participants, containing no confusing or ambiguous questions so as to increase the response rates and improve the quality of the data. In particular, the committee’s comments helped the researcher to rephrase question 10 from the executives’ questionnaire, and question 8 from the medical staff’s questionnaire, assuring that the wording is acceptable to the committee. Following the revision of those questions along with the revisions that took place following the pilot testing process, the researcher managed to develop a good last version of the research instrument.

5.2.4 Sample description

This research focuses on the healthcare industry in northern Greece, investigating the dynamics of customer-driven service innovation and corporate venturing. The industry in question has undergone significant changes due to mergers of hospitals, leading to expansion of the established healthcare firms. This sequence of changes has affected the mental health sector, in which a remarkable improvement is noticed in terms of decentralisation. However, more steps need to be taken for the enhancement and provision of mental healthcare services. In addition, the mental health service sector of the examined region is not well-developed, despite the fact that patients’ needs and requirements are not fulfilled by public mental health hospitals. Consequently, the theoretical gap of the customer-oriented service innovation and the entrepreneurial opportunities that might derive from such activities is particularly unexplored in the examined research context of northern Greece. In addition, the researcher is linked to the healthcare sector of Northern Greece, as he was working at one of the largest healthcare groups in Greece. This activity allowed him to participate in and collaborate with a network of hospitals, executives and medical personnel. The researcher’s experience and close ties with the industry empowered him to investigate those theoretical concepts in a field that had not been examined. All in all, the researcher considered the lack
of theoretical advancement in the fields of service innovation, customer orientation and corporate venturing along with the conditions in the mental health sector in northern Greece when planning the strategy for the research context and sampling. The details of the sampling strategy are described herebelow.

The executives were selected to provide information about the overall innovation strategy and new service development methods, activities and initiatives of the sample hospitals. Likewise, the medical staff was selected as they are well aware of the conditions and operational procedures within the hospitals; the treatment services offered to customers; their aspect on whether mental service users may contribute in addition to the unit’s service innovation efforts together with their willingness to improve the quality of the provided services. The researcher conducted initial, informal discussions with the CEOs and Scientific Directors of the case hospitals, describing and analysing the purpose and objectives of this study. Following these discussions, in which the researcher received verbal consents to involve these organisations in his study, he organised exploratory, unofficial visits to the premises of the case hospitals, before the interview process begins in an effort to meet with and introduce himself to the potential interviewees at a mutually convenient time, and present and discuss the purpose of the research. The administrators of the case hospitals will be the contact points for the researcher. He will arrange these visits with the administrators, requesting permissions of the executives to conduct the visits, providing enough time in advance (i.e. one week) to potential participants to be informed. For the same purposes, an introductory letter (i.e. the participant information sheet) was handed to them, describing the type, purpose and objectives of the study and interviews, the expected duration of the interview, the methods to contact the researcher after the interview process completes, clarifying that they would be conducted at interviewees' convenience and should give assurances about confidentiality. A week after those exploratory visits, the researcher followed up to see how many of the potential interviewees were willing to participate in the study. Following this step, a schedule of the visits for interviews was developed with the administrators of each hospital.

More specifically about research phase 1, data collection was based on in-depth élite interviews with top executives and managers from the case mental health hospitals (see Table 5.4). The group consisted of the case organisations Chairmen or CEOs, Business Development
Directors, Directors of Quality and Medical Services, and Hospital Managers. Studies by Polit and Beck (2010), and McDermott and O’Connor (2002) emphasise that this approach offers a thorough understanding and a richer portrayal of the case being studied. Participants were selected because they have deep knowledge of their organisations’ innovation and entrepreneurial activity, so the information acquired could be compared and treated as being highly credible. This sampling technique is called purposive. The definitions below explain in detail the reasons why this method was employed.

Schatzman and Strauss’s study (1973), and more recently Ohman (2005) suggest that, in such cases, researchers prefer participants consistent with the aims of the study. Another study by Morse et al. (2002) adopted this viewpoint and stated that researchers choose a dynamic sample to respond to research questions. Additionally, the study by Marshall (1996, p. 523) adds, “This can involve developing a framework of the variables that might influence an individual's contribution and will be based on the researcher's practical knowledge of the research area, the available literature and evidence from the study itself. This is a more intellectual strategy than the simple demographic stratification of epidemiological studies.” However, Tansey (2007), who carried out research to examine the relationship between the method of process tracing and the data collection technique of elite interviewing, defines purposive sampling (p. 770) as “a selection method where the study’s purpose and the researcher’s knowledge of the population guide the process. If the study entails interviewing a pre-defined and visible set of actors, the researcher may be in a position to identify the particular respondents of interest and sample those deemed most appropriate.”

<table>
<thead>
<tr>
<th>Firm/Organisation</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thermaikos Hospital</td>
<td>Managing Director</td>
</tr>
<tr>
<td>Thermaikos Hospital</td>
<td>Director of Quality</td>
</tr>
<tr>
<td>Thermaikos Hospital</td>
<td>Hospital Manager</td>
</tr>
<tr>
<td>Thermaikos Hospital</td>
<td>Business Development Manager</td>
</tr>
<tr>
<td>Thermaikos Hospital</td>
<td>Medical Services Manager</td>
</tr>
<tr>
<td>Castalia Hospital</td>
<td>Hospital Manager</td>
</tr>
<tr>
<td>Castalia Hospital</td>
<td>Business Development Manager</td>
</tr>
<tr>
<td>Castalia Hospital</td>
<td>Quality and Medical Services Manager</td>
</tr>
<tr>
<td>Castalia Hospital</td>
<td>Patient Services and Admissions Manager</td>
</tr>
<tr>
<td>Galini Hospital</td>
<td>CEO</td>
</tr>
<tr>
<td>Galini Hospital</td>
<td>Hospital Manager</td>
</tr>
<tr>
<td>Galini Hospital</td>
<td>Business Development Manager</td>
</tr>
<tr>
<td>Galini Hospital</td>
<td>Medical Services Manager</td>
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</tbody>
</table>
For research phase 2, data collection was based on interviews with medical staff from the case study hospitals. The sample consisted of the Scientific Director (psychiatrist), the pathologist (medical generalist), the psychologist, the occupational therapist and the social worker as well as the head of the nursing service (see Table 5.5). Similar to the sample in the previous research phase, informants were selected because they are well aware of the health conditions within hospitals as well as the treatment services offered to customers. It was also important to interview key stakeholders, who would share their opinion on whether mental service users may contribute usefully to the unit’s service innovation efforts.

### Table 5.5 Participant list for research phase 2

<table>
<thead>
<tr>
<th>Firm/Organisation</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saint Irene Hospital</td>
<td>Scientific Director (psychiatrist)</td>
</tr>
<tr>
<td>Saint Irene Hospital</td>
<td>Pathologist (medical generalist)</td>
</tr>
<tr>
<td>Saint Irene Hospital</td>
<td>Psychologist</td>
</tr>
<tr>
<td>Saint Irene Hospital</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Saint Irene Hospital</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Saint Irene Hospital</td>
<td>Head of the Nursing Service</td>
</tr>
<tr>
<td>Castalia Hospital</td>
<td>Scientific Director (psychiatrist)</td>
</tr>
<tr>
<td>Castalia Hospital</td>
<td>Pathologist (medical generalist)</td>
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<tr>
<td>Castalia Hospital</td>
<td>Psychologist</td>
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<tr>
<td>Castalia Hospital</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Castalia Hospital</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Castalia Hospital</td>
<td>Head of the Nursing Service</td>
</tr>
<tr>
<td>Eleftheria Hospital</td>
<td>Scientific Director (psychiatrist)</td>
</tr>
<tr>
<td>Eleftheria Hospital</td>
<td>Pathologist (medical generalist)</td>
</tr>
<tr>
<td>Eleftheria Hospital</td>
<td>Psychologist</td>
</tr>
<tr>
<td>Eleftheria Hospital</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Galini Hospital</td>
<td>Scientific Director (psychiatrist)</td>
</tr>
<tr>
<td>Galini Hospital</td>
<td>Pathologist (medical generalist)</td>
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<tr>
<td>Galini Hospital</td>
<td>Psychologist</td>
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<tr>
<td>Galini Hospital</td>
<td>Occupational Therapist</td>
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<tr>
<td>Galini Hospital</td>
<td>Social Worker</td>
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<tr>
<td>Galini Hospital</td>
<td>Head of the Nursing Service</td>
</tr>
<tr>
<td>Thermaikos Hospital</td>
<td>Scientific Director (psychiatrist)</td>
</tr>
<tr>
<td>Thermaikos Hospital</td>
<td>Pathologist (medical generalist)</td>
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<tr>
<td>Thermaikos Hospital</td>
<td>Psychologist</td>
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<tr>
<td>Thermaikos Hospital</td>
<td>Occupational Therapist</td>
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<tr>
<td>Thermaikos Hospital</td>
<td>Social Worker</td>
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</table>
5.2.5 Qualitative data analysis

Studies argue that qualitative research is of increased interest in health services (e.g. Neergaard et al., 2009; Shortell, 1999; Sofaer, 1999); however, no considerable attention has been paid to the approach and methods of data analysis (Bradley et al., 2007). Studies by Thorne (2011), Srivastava and Hopwood (2009), and Fossey et al. (2002) report that qualitative research techniques establish guides and associations between elements of data and therefore, data analysis is a compound and mysterious process in qualitative studies. Therefore, there is a need to define qualitative analysis. Many studies provide definitions. For example, a study by Fossey et al. (2002, p. 728) argues that qualitative analysis “...is a process of reviewing, synthesizing and interpreting data to describe and explain the phenomena or social worlds being studied.” Another study by Pope et al. (2002) enhance this viewpoint stating (p. 149) that “this may be done inductively—that is, obtained gradually from the data—or deductively—that is, with a theoretical framework as background, either at the beginning or part way through the analysis as a way of approaching the data”. Likewise, a study by Miles and Huberman (1994) goes a step forward mentioning the three sequential stages of the analysis: data reduction; data display and conclusion drawing/verification (Figure 5.6). Data reduction, which transpires early in the analysis, has reference to the procedure of summarising, selecting, coding, and categorising the information to direct it towards essential aspects of the questions under consideration. By data displays, Miles and Huberman (1994, p. 91) describe a “visual format that presents information systematically, so the user can draw valid conclusions and take needed action.” In other words, it refers to the process of organising and collecting the data with a distinct focus and aims that lead to conclusion drawing and action. Conclusion drawing and verification includes interpretation of the information gathered, formation of patterns, and detection of rationalisation. It also relates to the emergence of meanings responding to the research questions (Miles and Huberman, 1994; Sarantakos, 2005).
The data collected were subjected to qualitative cross-case analysis by the researcher. Analysis of relevant literature and documentation, along with the findings of the interviews allowed for the creation of a new conceptual approach to organizational strategy in this study (see Section 4.3). Cross-case analysis is a means of grouping together common responses to interviews as well as analyzing different perspectives on central issues (Patton, 1990). A cross-case study strategy explains the causal links in real-life situations that are too complex for a single survey or experiment (Yin, 1994). Undertaking multiple case studies can generate explanations and test them systematically (Miles and Huberman, 1994). The use of multi-case sampling adds to the validity and generalisability of the findings (Miles and Huberman, 1994) through replication logic (Eisenhardt, 1989; Yin, 1994). The cross-case analysis (Patton, 1990) consisted of looking for patterns that were similar and different across the case hospitals with respect to their innovation activities and strategies for patient involvement. Yin (1994) supports this approach, suggesting that appropriate causal links can be analysed within complex multi-case studies using modes of analysis such as pattern matching, non-equivalent dependent variables as patterns, rival explanation as patterns, and simpler patterns. Simple pattern matching identifies a certain outcome as a dependent variable and explores how this outcome has occurred in each case, that is, the independent variables. A general analytic strategy identifies important differences in the patterns observed as a way to develop a theoretically significant explanation for the different outcomes. One method suggested by Eisenhardt (1989) for searching for patterns within cross-case studies is identifying dimensions or constructs from the literature, and then looking for within-group similarities.
and inter-group differences. Iterative comparison of theory to data allows constructs to be identified from multiple sources of information to provide construct validity.

Strategic Group Mapping (SGM) is a method for structural analysis of industries (Porter, 1980). This study assesses whether SGM principles can be adapted to explanatory research as a technique to improve internal validity in a cross-case analysis. Miles and Huberman (1994) suggest that complex networks of conditions and outcomes can be analysed through cause-and-effect models to antecedent or probable cause variables. SGM displays competition within an industry, based broadly upon strategic approach; firms with similar strategic approaches are grouped together. SGM describes the competitive environment in ‘strategy-space’. Porter (1980) defines strategy as the matching of a firm’s strengths and weaknesses (particularly distinctive competencies) to the opportunities and risks in the competitive environment. SGM can determine the strategic opportunities (e.g. the advantages of developing a new strategic group through new technology or market dynamics), indicate the most appropriate strategic group to enter, and evaluate the investments required to reposition a firm within a group or to enter other strategic groups. Firms within each group tend to have the same characteristics and strategies, and so they tend to be affected by and respond similarly to external events or competitive pressures. This research uses the principles of SGM to identify the antecedent causes (independent variables) of an observed phenomenon (dependent variable).

A cross-case analysis of 5 small- and medium-sized mental health hospitals was performed to assess the use of SGM as an explanatory analysis technique, identifying antecedent variables to a predicted outcome. Studying one industry has several advantages: single industries are common while they have long been used for study in strategic marketing and management disciplines, and they provide greater control of extraneous variation (Conant et al., 1993; Eisenhardt, 1989; Weischedel et al., 2005). Furthermore, Porter (2004) considers no one generic model can fit all organisations, and so the study of the competitive nature of business must be conducted for specific industries. By grouping answers together according to questions, themes, or central issues, the interview questions provide the descriptive analytical framework and the basis for comparison of the case organisations studied. The current analysis is based on three main themes that are common to customer-
driven service innovation and entrepreneurship research—namely, service innovation, customer orientation, and growth and development. It should be noted that other strategies for analyzing case studies are possible, including a focus on key events, various settings, people, processes, or issues.

Data analysis was performed throughout by a broad and thorough procedure as set out by Creswell (2012). At the early stage of the qualitative analysis interviews were transcribed to produce manuscript that could be used to generate coding categories and test theories. Before transcriptions were coded, each transcript was examined carefully to enable a thorough understanding of its value. A guide to themes then emerged, using a category system for data reduction and coding in line with both the initial theoretical framework and the conceptions that had been developed by the interviewees. The next step followed the process employed by Lindgren and O’Connor (2011), who classified interview data and organised them thematically to compare organisation, operation and strategy among case study sites as well as participants’ viewpoints. This systematic process concerns the description of managerial practices, the interpretation of decisions and actions, as well as the search for patterns and dynamics among data (Lindgren and O’Connor, 2011). Likewise, the study by Pope et al. (2002, p. 149) reports, “when conducting this coding analysis the researcher gives consideration to the actual words used, the context, the internal consistency, the specificity of responses that is more based on one’s own experiences of respondents, and the big ideas beneath all detailed information”. As regards conclusion drawing and data verification, one would apply the notion of Rohrbeck and Gemünden (2011), who recommend that a researcher should follow the theoretical framework, identify and assess rival explanations and make a case description.

5.2.6 Limitations of research methods

The shortcoming of the research techniques employed regards the sample range and sample frame. For instance, research phase 1 could engage a higher quantity of individuals in a broader field of health service organisations, increase and enrich the amount of data to increase credibility and authority of the results and to pluralise the inferences to the mental healthcare sector. Likewise, additional medical and nursing staff would probably increase the
reliability of the findings. However, this was not possible for the case study hospitals, as all members of the medical and nursing staff participated in the research.

5.3 Synopsis of the date collection and analysis processes

In the current climate of economic and fiscal uncertainty, the executives of the case hospitals and other key shareholders were understandably preoccupied with the prospects of facing future reduction budgets and expressed the intent to improve effectiveness without increasing costs. The employees seemed prepared to engage in the delivery of customer-oriented services. There is an awareness on their part of existing ideas on good practice and a great number of employee participants expressed willingness to build on these. At board levels, though attitudes seem more sceptical about acknowledgement and ownership of patients in service design and implementation. Ritchie et al. (2013) suggest that researchers who undertake research in a setting where they can understand participants’ and even identify their point of view are more likely to gain a richer interpretation of their data. This process in qualitative research can result in better rapport with participants and thus in more valid conclusions. To make sure that participants feel comfortable about confiding about their role and contribution to service processes within the particular care context, the researcher dedicated considerable time to establishing an environment of unconstructive communication with participants taking great care to listen to their views and feelings in a responsive and empathetic manner. The form of open-ended interviews helped particularly in creating the appropriate context for meaningful and honest communication where participants were allowed to expand on their answers and lead the discussion in areas they felt mattered to them.

Throughout this research, the goal of the researcher and part of his methodological focus was to encourage self-reflections for all participants and unlock well-established structures or hierarchies of authority and prestige that inform the mental health sector. It has been established that the existing power and hierarchy structures within the hospital settings are still generally geared in favour of medical professionals. Power sharing and authentic communication is still resisted by a number of professionals and organisations’ shareholders who oppose the validity of user inclusion in decision-making processes. They support this view
on the grounds of users’ perceived incompetence to participate in professional structures. It seems that they are emotionally unprepared to engage in deep and meaningful debate about users’ active inclusion and hold on to professional constructions of identity, power, and status. This trend is noticeable among executives and managers within the organisations. On the contrary, medical and nursing staff demonstrated higher levels of awareness of the benefits of user involvement. They have demonstrated awareness of what consists a ‘good practice’ but remain largely confused as to how exactly such steps towards user empowerment should be implemented.

5.3.1 Cross-language qualitative research

Due to the forces of globalisation augmentation, there is an increasing need for qualitative research that is linguistically and culturally representative of participants of each study to improve the quality of the latter. The term ‘cross-language research’ was first used by professionals to describe qualitative studies that require the use of a translator or interpreter at any point during the research process and it is now regularly used to describe this kind of research (Croot et al., 2011). In other words, when a language barrier exists between qualitative researchers and their participants, the research becomes a cross-language qualitative study that is characterised by unique challenges related to language (Berman and Tyyskä, 2011). Commonly, researchers employ interpreters or translators to overcome that language barrier, and the way the former use the services of translators and interpreters in their study can affect the results that are obtained from participants (Temple and Edwards, 2008).

Trustworthiness is a measure of a qualitative study’s rigor, which is evaluated by qualitative researchers by linking the trustworthiness of qualitative data to the competence of the researcher orchestrating the study (Squires, 2009). A study by Hsin-Chun Tsai et al. (2008) about the development of culturally competent health knowledge showed that in the case of cross-language qualitative research, inconsistent or inappropriate use of translators or interpreters could threaten the trustworthiness of the study and consequently, the applicability of the translated findings on participant populations. Subsequently, using that standard with cross-language research, the way researchers describe the role of translators in cross-language qualitative research reflects their competence in addressing language as a
methods issue. Several methods articles raising the issue of cross language research have appeared since 2000, providing salient points about difficulties related to cross-language research, however, no methodological consensus has resulted from them (e.g. Harnsberger, 2000; So and Best, 2010; Williamson et al., 2011). Employing translators and interpreters provide language translation services. Even though many use the terms without change, the two roles provide distinct services (Temple and Edwards, 2008). For instance, when researchers need written documents translated from one language to another - such as interview transcriptions or primary and secondary sources - they employ a translator. On the contrary, they employ an interpreter when translations to conduct an interview or focus group are required, as the role of the interpreter provides oral translation services during an interaction between a minimum of two people who do not speak the same language. Because different qualitative methods also require different roles for translators, researchers who fail to systematically address the methodological issues that translators situate in a cross-language qualitative research design can decrease the trustworthiness of the data and, by extension, the overall rigor of the study (van Nes et al., 2010). Since the translator and interpreter roles have been distinguished, in the following section of this study several methodologically important issues for addressing language barriers between qualitative researchers and their participants will be discussed. These include maintaining conceptual equivalence, translator credentials, the translator or interpreter’s role in the research process.

Equivalence of the concept

Changes to language occur during the process of translation, as when a translator performs a translation, they translate not only the literal meaning of the word, but also the way the word relates conceptually in the context, which might be the sentence itself, or the place where the person speaks it. The term 'conceptual equivalence' means that a translator provides an accurate; both technically and conceptually, translated communication of a concept spoken by participant in the study (e.g. Croot et al., 2011; Squires, 2009). Consequently, when a poor translation occurs, the researcher may lose the conceptual equivalence, or find the meanings of the participants’ words altered by the way the translator performed the translation.
Credentials

For the above reason, it is obvious that the credentials of a person providing translation services are important, as both credentials and experience will affect the quality of translations produced by the translator and become especially crucial during the qualitative coding and data analysis processes. Poorly translated concepts or phrases will have a massive impact on the findings as they will change the themes emerged from the analysis and may not reflect the actual words of the participant, threatening the credibility and dependability of the cross-language study and form part of the limitations of the study. Therefore, for research purposes, experts recommend that translators or interpreters should have a minimum of sociolinguistic language competence when providing translation service (Berman and Tyyskä, 2011). When translators or interpreters have this level of language competence, they actually prove the ability to communicate between languages using complex sentence structures, demonstrating a high level of vocabulary, in addition to the ability to describe concepts or words in cases they do not know the actual word or phrase (e.g. Squires, 2008). With this level of language competence, it can be ensured that translated data is less likely to have errors related to translation. It is, therefore, ideal to employ translators or interpreters to participate in a cross-language study possess certification that come from a professional translator’s association, like the American Translators Association, as they are credentialed individuals who have had their language competency verified through a combination of educational and experiential criteria.

Roles during the research process

Based on the language competencies of the researchers and translators, the primary investigator or research team, determines the best roles for each person that takes part in the study. This process needs attention since the role of the translator or interpreter forms an important component of the research process, affecting data collection, results, costs of research, and degree of bias in the results (So and Best, 2010). The researcher’s theoretical or philosophical approach in the study influences the translators or interpreters roles in research (e.g. Williamson et al., 2011). For instance, a positivist researcher expects only a technically accurate translation, while a social-constructionist researcher takes under consideration the effects of translator or interpreter identity on translation services. The latter perspective
requires cultural interpretation of the participant’s statements into the data analysis process, and expects the translator to become a producer of research data who shapes the analysis through their identity and experiences.

Different qualitative approaches

Most qualitative research approaches are amenable to cross-language designs. However, phenomenological studies that require translation of responses are not amenable to such designs (e.g. Temple and Young, 2004). Those studies require an intense, exact focus on how participants use language to describe their experiences, and since language is considered part of the identity of the person experiencing the phenomenon, translation disrupts the fluid process from inception through dissemination of studying the participants’ use of language to describe the experience of the phenomenon. As it has been indicated earlier in this study, the process of translation alters the original use and, in some cases, the structure of the participant’s use of language and the text may change enough during the translation process that the investigator will not adequately capture the essence of the phenomenon in the translated language. Based on the above, phenomenological studies can only take place in the language of the participant and cannot involve use interpreters or translators during data collection or analysis.

On the other hand, narrative analysis can capture the experiences of participants with fewer methodological issues related to translation. For example, in the case of international historical or case study research, the researchers themselves must have a high level of language competence to complete their studies, as the majority of translation when using these methods is performed by them and sometimes they may opt not to use a translator (Temple, 2008). For this reason, the investigator has to have a high-level sociocultural competence and significant background knowledge about the country or place of study. Nevertheless, in cases where the researcher plays both his and the role of the translator or interpreter, the literature recommends an independent review to validate the technical and conceptual accuracy of the translation, to ensure credibility and conformability of data and findings translated by the former, and by extension, to enhance the study’s rigor (Temple et al., 2006). A certified translation centre in Thessaloniki, which specialises in translating
business related documents and terms, helped the researcher of this study to validate the translation of the responses, enhancing the credibility of the research.

5.3.2 Reflection on qualitative research

Reflectivity entails the researcher being aware of the impact he has on the process and conclusions of research, something that is based on the belief that ‘knowledge cannot be separated from the knower’ (Steedman, 1991) and that, “In the social sciences, there is only interpretation. Nothing speaks for itself” (Denzin, 1994, p. 500). Consequently, in carrying out qualitative research, it is impossible for the researchers to remain ‘outside’ the subject in question, since their presence will have some kind of effect, which can take any form. Reflective research takes account of this researcher involvement, as well as the concept and practice of reflectivity have been defined in many ways. For example, Alvesson and Sköldberg (2000) describe it as the ‘interpretation of interpretation’, meaning another stage of analysis after data have been interpreted, and Woolgar (1988) presents reflectivity as ‘the ethnographer [q.v.] of the text’ (p. 14).

Reflectivity focuses on the importance of self-awareness, political and cultural consciousness, as well as ownership of someone’s perspective (e.g. Alvesson and Sköldberg, 2009). Being reflective involves both self-questioning and self-understanding, since to be reflexive is to undertake an ongoing examination of what I know and how I know it. Reflectivity works as a reminder to the qualitative researcher to be attentive to and conscious of various issues that may have an impact on their research, such as the cultural, political, social, linguistic, and ideological origins of his or her own perspective (Ellis and Bochner, 2000). Unlike in quantitative research, reflectivity is particularly important in qualitative research, in which the researcher is the instrument that interprets the qualitative data collected to reach findings and conclusions (Glesne and Peshkin, 1992). Therefore, it is obvious that the credibility and reliability of qualitative methods depend largely on the skill, competence, and rigor of the researcher doing the fieldwork. However, it might be also affected by things going on in his or her life that might prove a distraction and may lead to prejudices and bias, thereby providing invalid research and research that is not good. They need to ask constantly themselves questions to ensure there are no interferences affecting their work and lead to equal results. But, how should researchers reflectively evaluate ways in which intersubjective elements
transform their research? The process of engaging in reflectivity is full of multiple trails as researchers negotiate the swamp of interminable deconstructions, self-analysis and self-disclosure; guidelines are offered by five variants of reflectivity, that involve introspection, intersubjective reflection, mutual collaboration, social critique and discursive deconstruction, each of which has a variety of opportunities and challenges (Ellis and Bochner, 2000).

**Introspection**

According to Maslow (1966), there is no substitute for experience, pointing researchers towards the value of self-dialogue and self-discovery. Those researchers who begin their research with the data of their experience seek to “embrace their own humanness as the basis for psychological understanding” (Walsh, 1995, p. 335). In this case, researchers’ own reflecting, intuiting and thinking are used as primary evidence, as believed by Moustakas (1990), who describes this process in terms of forming the research question: “The task of the initial engagement is to discover an intense interest, a passionate concern that calls out to the researcher” (p. 27). His main phenomenological work on loneliness, for example, began at a critical time in his life when he was faced with a problem of whether or not to agree to major heart surgery that might restore his daughter to health or result in her death. “The urgency of making a critical decision plunged me into the experience of feeling utterly alone. I became aware that at the center of my world was a deep and pervasive feeling of loneliness” (p. 91).

In different circumstances, Moustakas (1990) describes heuristic research as the process of internal search through which the researcher discovers meaning. In addition to examining one’s own experience and personal meanings for their own sake, insights may result from personal introspection which then form the basis of a more generalised understanding and interpretations, as reflections are assumed to provide data regarding the social/emotional world of participants. A representative example of this comes from Rosaldo (1989) in his influential anthropological study of Ilongot head-hunting, where he drew on his personal experience of the death of his wife to make sense of the rage people felt which pushed them to head-hunting. Additionally, the use of personal data is also picked up by psychodynamic researchers who explore how unconscious fantasies can be mobilised in research encounters. Kracke’s anthropological work (see Hunt, 1989) with South American Indians, for instance, provides a good picture of how competition with father images and castration anxieties
became important themes on noting how the tribe openly expressed feelings and fantasies that were normally disguised in Western cultures.

The above examples show the value of using introspection and being reflexive about one’s own personal reactions. However, being preoccupied by one’s own emotions and experiences can result into misinterpreted or wrong findings. On the other hand, the researcher’s position can become unduly privileged, blocking out the participant’s voice. Consequently, there is a need to strike a balance, striving for enhanced self-awareness while eschewing navel-gazing. Ultimately, reflectivity should be “neither an opportunity to wallow in subjectivity nor permission to engage in legitimised emoting” (Finlay, 1998, p. 455). The challenge for researchers using introspection is to use personal revelation not as an end in itself, but as a source of and a basis for interpretations and more general insight to move beyond ‘benign introspection’ (Woolgar, 1988, p. 22) and to become more explicit about the link between knowledge claims, personal experiences of both participants and researcher. The above is important as carries through into the second variant of reflectivity that sets an argument against individual subjectivity dislocated from research relations, while it is in favour of intersubjective reflection.

*Intersubjective reflection*

The genre of reflectivity as intersubjective reflection has grown significantly in the last decade. In this case, researchers explore the mutual meanings that emerge within the research relationship, focusing on the situated and negotiated nature of the research encounter and, for those of a psychodynamic persuasion, how unconscious processes structure relations between the researcher and participant. Intersubjective reflection involves more than reflection, but instead, it requires radical self-reflective consciousness (Sartre, 1969) where the self in relation to others becomes both the aim and object of focus. Research by Ballinger and Payne (2000) about falls that are experienced by older people highlights how the researcher can be viewed by the patient participants as a ‘professional with some kind of authority and influence’, an interpretation which would impact on subsequent interactions. When an analysis of discourse was carried out, these observations enabled them to understand the way and the reasons that participants seemed engaged in a project, as they wanted to avoid negative professional evaluations that they were mentally or physically frail.
Psychodynamically orientated researchers, such as Hollway and Jefferson (2000), utilised reflectivity along with their narrative method using psychoanalytic interpretations. They recommended the use of self-reflection while suggesting a variety of psychoanalytic techniques such as dream analysis and interpretation of fantasies as research tools to enable researchers to become aware of the emotional investment they have when the research relationships are concerned. Additionally, psychodynamic researchers advise us to explore the way verbal and written word affects us and to reflect on what we bring to it ourselves, as in particular, they believe that unconscious needs and transferences mutually structure the relationship between researcher and participant (e.g. Orlinsky et al., 1993; Beail, 2003). The value of exploring the research relationship as well as the challenges entailed is highlighted; the difficulties of gaining access to personal and possibly unconscious motivations should not be underestimated while the complex dynamics between the researcher and participant adds a further layer of opacity. It could be argued that to accomplish such a feat a ‘superhuman self-consciousness’ is required, which is only attainable through intensive psychoanalysis (Seale, 1999). However, researchers interested in exploring intersubjective dynamics defend their efforts to explore the co-constituted nature of the research by looking at both inward meanings and outward into the realm of shared meanings, interaction and discourse, which also provide the focus for researchers interested in collaborative enquiry.

**Mutual collaboration**

Researchers making use of reflectivity as mutual collaboration use a wide range of methodologies that ranges from humanistic new paradigm and co-operative inquiry research (e.g. Reason, 1988; Heron, 1996) to more sociological, discursive and feminist research approaches (e.g. Wilkinson, 1988; Banister et al., 1994; Potter and Wetherell, 1995; Yardley, 1997). These wide-ranging research methodologies are connected by the way they endeavour to enlist participants as co-researchers and vice versa; as recognising research as a co-constituted account gives the research participants, who also have the capacity to be reflexive beings, the opportunity to be co-opted into the research as co-researchers, adherents of participative research argue. According to them, this involves participants in a reflexive dialogue during either the stage of data analysis or evaluation. As Smith (1994) cites utilising participants’ interpretations resulted in confronting, modifying and forming his own
interpretations. On the other hand, co-operative inquiry approaches apply reflectivity more completely. In this case, researchers act simultaneously as participants in their own research, engaging in cycles of mutual reflection and experience. A reflexive study of interactive interviewing by Ellis et al. (1997) provides insights into the way a research relationship develops and shapes the findings produced. They describe (p. 21) their work as “sharing personal and social experiences of both respondents and researchers, who reveal their stories in the context of a developing relationship, as the researchers themselves experience the eating disorder of bulimia”. Additionally, Heron (1996) describes a co-operative inquiry where the co-researchers or co-participants, engage in a reflexive dialogue about their research process, as Traylen (1989) draws this into the role of health visitors.

It is obvious that these studies are to be valued for their collaborative, democratic and inclusive spirit; however, critics reject the pronounced element of compromise and negotiation as it could potentially ‘water down’ the insights of single researchers. Answering to the criticism, collaborative researchers, as Halling (1994), who carried out a dialogic study on forgiveness in collaboration with a group of post-graduate students, argues that dialogue within a group enables members to move beyond their preconceived theories and subjective biases, towards representing multiple voices. Consequently, collaborative reflectivity offers the opportunity to hear and take into account multiple voices and conflicting points of view. Nevertheless, while the belief of shared realities finds favour to many researchers, some still question an egalitarian rhetoric, which disguises essentially unequal relationships, an issue that is taken up in the fourth variant of reflectivity.

Social critique

Using reflectivity as social critique raises one particular concern for researchers on the way to manage the power imbalance between researcher and participant, since they openly acknowledge tensions arising from different social positions, for instance, in relation to class, gender and race (e.g. Marshall et al., 1998; Gough, 1999). It has to be mentioned that, even though reflexive research focused on social critique arises out of the social constructionist and feminist literature, researchers of other theoretical persuasions also pick up these themes. This might be because reflectivity as social critique offers the opportunity to utilise experiential accounts and, at the same time, situating these within a strong theoretical
framework about the social construction of power. A particular strength with this account is the recognition of multiple, shifting researcher/participant positions. However, the task of deconstructing the researcher’s authority carries associated costs, similar to the ones in relation to the previous variant. Preoccupations with egalitarianism can drive attention away from other, possibly more pertinent, issues and may result, paradoxically, in a strategy, which aims claim to more authority. Such rhetorical strategies are the focus of the fifth and final variant of reflectivity.

**Discursive deconstruction**

In reflectivity as discursive deconstruction, attention is paid to the ambiguity of meanings in language used and what impact it has on the available ways of presentation. The main question asked by the researchers, consequently, is how they can pin down and represent the dynamic, multiple meanings embedded in language. Answering that question, Woolgar (1988) suggests one route to achieve such representation is to juxtapose “textual elements such that no single (comfortable) interpretation is readily available. In this scheme, different elements manifest a self-referring or even contradictory relation with one another” (p. 85). Ashmore (1989), in his thesis on ‘Wrighting sociology of scientific knowledge’, plays upon the circumstances of the production of his doctoral thesis by creating entertaining, fictional dialogues with literature reviews and dialectical critique. Additionally, researchers inclined towards social constructionism focus more explicitly on deconstructing the language used and its rhetorical functions, while for this tradition they would notice that both participants and researchers are engaged in an exercise of ‘presenting’ themselves to each other.

Other post-modern researchers have focused on reflexive writing itself in terms of textual radicalism. In that context, Lincoln and Denzin (1994) explain how textual experimentation reflects a move towards a post-modern pluralism, which is needed to be reflected in qualitative research. Accordingly, in the case explained above, there is ‘not one voice, but polyvocality; not one story but many talks, dramas, pieces of fiction, fables, memories, histories, autobiographies, poems and other texts’ (p. 584). Reflectivity to deconstruct gives post-modern researchers the opportunity to be creative and powerfully thoughtful, provoking if they find a balance so as not to lose all meaning. According to MacMillan (1996, p. 16), “exposing the construction of a text could be viewed as undermining
the strength of its own position, since deconstruction can clearly be applied to itself, with the researcher’s analysis deconstructing (decomposing) before the ink has dried upon the page.”

5.4 Summary of chapter

This chapter demonstrates the research methodology. All the steps of the study align with the research questions and conceptual framework mentioned in the previous chapters. The research design in this study consists of two phases. The first is related to corporate and hospital research, aiming at collecting data from the organisations’ executives and the managers of the hospitals. In-depth elite interviews with 20 executives and hospital managers were employed to answer the following two research questions: “Where, how and why should patients be involved in new service development?” and “How and to what extent is corporate venturing developed by adopting service innovation initiatives?” Well-designed tools for collecting data result in reliable research outputs. The questionnaire was validated by the consulting supervisor and by experts using the IOC index. In this study, the researcher used the interview guide to collect the data. Then, the collected data were analysed following three different stages: data reduction and coding, data organisation and classification, and data verification and conclusion drawing (Miles and Huberman, 1994; Lindgren and O'Connor, 2011; Rohrbeck and Gemünden, 2011).

The second research phase involves the medical staff and aims to collect data about the involvement and their perceptions regarding patient contribution in new service development. Semi-structured exploratory interviews with 30 members of the five hospitals’ medical staff was conducted to answer the following research questions: “How do medical personnel perceive patient involvement in new service development?”, and “What is the role of medical personnel in patient-oriented service development?” Using the questionnaire of the previous section, 12 questions were considered relevant and valid to investigate the opinions and perceptions of medical staff regarding patient participation. Similarly to Phase 1, the interview guide for collecting data is used, and then, these data are analysed.

The next chapter discusses the findings of the research regarding the innovation activity within the case hospitals and the role of patients. It also reviews the development of healthcare services within the organisations, the strategic plan for the expansion of services
as well as the level of coordination among people and departments throughout the service development process. Additionally, it examines the entrepreneurial model and activity of the case companies, reviewing also the patient involvement activities and initiatives that have been undertaken.
This chapter explores the operation of the five case hospitals and discusses the conditions for patient involvement in day-to-day care. It explores the results of the élite in-depth interviews performed with top executives as well as investigates their opinion regarding the factors that determine innovative activity, the tools and processes applied to new service development, the contribution of customers, the role of executives and medical personnel in the innovation process, and the level of customer involvement in new health service development. A series of strategic issues linked to the process of new service development, venture creation and customer orientation were investigated in this chapter, including: the factors that force the companies to be innovative; the coordination among people and departments throughout the new service development process; the business culture and the incentives for staff to identify and act on opportunities for improvement; the processes to track and respond to customer queries; and the methods that fuel service development initiatives. Managerial perspectives regarding entrepreneurial opportunities within the healthcare industry and customer orientation in health services provision were also examined.

To answer research questions 1 and 4 (see section 1.2.3), the élite in-depth interviews were employed as a technique. The results of those interviews, conducted with 20 senior executives and hospital managers, were then examined to deal with the research questions. The results from the interview data were analysed and categorised into four categories – innovation, new service development, corporate venturing, and customer orientation – based on the conceptual framework. These findings are presented in the following sections. The first research phase was led by two research questions: RQ1 and RQ4. Figure 6.1 illustrates that the propositions that emerged from the research questions guided to the collection of data from the executives, hospital managers, and heads of departments. The researcher gained insights on customers’ involvement in new service development and exploitation of service innovation for corporate venturing. Those insights and the combination of answers and different perspectives led to the mapping of the key findings.
6.1 Description of research sample and instrument

In line with the discussion on the data collection for Phases 1 and 2 in the previous chapter (see Section 5.2.2), the participants consisted of two groups, with the hospital managers and executives (20 participants), and the medical personnel (30 participants) covering the wide range of interviewees for the five case hospitals. The study used expert sampling, a form of judgemental or purposive sampling. As stated earlier, purposive sampling is used by the researchers who aim to identify a specific type of case for detailed investigation (Tansey, 2007).

Table 6.1 displays the objectives and the role of each question that was used to further explore the key areas of this study. The basic characteristics of the firms under study, including information concerning both pre- and post-production, are taken into account before empirical analysis is conducted. Four parts constitute the instrument that the researcher has used to collect information. The first part includes a list of questions about the firms’ innovation activity, culture, and structure. The second part investigates the companies’ new service activity, while the third part aims to illustrate the entrepreneurial model that the organisations follow, together with how entrepreneurial opportunities are identified and exploited. Finally, the last part explores the role of market assessment and customer involvement in hospitals’ service innovation strategy (for more details see Section 5.2.3 and Appendix 1). Likewise, Table 6.2 displays the objectives and the role of each question that was used to interview medical staff. As it was mentioned in Section 5.2.3, the questionnaire included some of the same questions used in the interviews with hospitals’ administrative staff. The aim of this action was to collect a similar kind of information, but from different
perspectives - that of administrative and medical staff to make comparisons. This tool aims to collect data regarding the hospital’s innovation activity, new service development process and the level of patient participation in hospital activities and initiatives (for more details see Section 5.2.3 and Appendix 2).

Table 6.1 Set of questions for top executives

<table>
<thead>
<tr>
<th>Questions</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are the internal factors that predispose the organisation to seek access to innovation?</td>
<td>Background information that aim to present the internal and external factors that affect innovation</td>
</tr>
<tr>
<td>2. How and to what extent do external factors such as legislation, social and economic, condition or stimulate favourable attitudes towards innovation?</td>
<td>To explore whether the hospitals use proper tools and processes, leading to the creation of opportunities for product development</td>
</tr>
<tr>
<td>3. Are adequate tools and processes used to generate opportunities for product development?</td>
<td>To examine whether there is a business culture that promotes innovation and acts on opportunities for improvement</td>
</tr>
<tr>
<td>4. Does the organisation do enough to create:</td>
<td>To investigate whether the case organisations take customer requirements into consideration to develop their innovation strategy</td>
</tr>
<tr>
<td>i. A culture where continuous improvement is regarded as a norm?</td>
<td>To explore whether the executives in question consider customers as key players of the innovation process</td>
</tr>
<tr>
<td>ii. Incentives for staff to identify and act on opportunities for improvement?</td>
<td>To understand how executives perceive themselves in the promotion of the innovation process</td>
</tr>
<tr>
<td>5. How adequately or appropriately are the requirements of customers taken into account in the organisation’s innovation strategy?</td>
<td>To investigate whether the executives appreciate the stimulus of growth as a factor for innovation</td>
</tr>
<tr>
<td>6. Do you believe that customers can contribute something extra to the service innovation process?</td>
<td>To explore whether the hospitals have developed such structure and organisation that enable the implementation of innovative actions and whether this has led to the development or improvement of services in its mental healthcare division</td>
</tr>
<tr>
<td>7. What do you think is the role of the top executives in promoting the internal innovation process?</td>
<td>To show whether the case organisations have developed and/or improved their services the recent years as well as whether there is a plan for the extension and evolution of their offerings</td>
</tr>
<tr>
<td>8. Do you believe that the stimulus of growth could help you become more innovative, developing new services and approaching new markets and why?</td>
<td>To explore the source of the main ideas for new services, as this is measurement tool of firms’ innovativeness</td>
</tr>
<tr>
<td>9. Do you believe that the organisation and the structure of the hospital help you to implement innovative actions? If so, how does this happening?</td>
<td>To investigate the level and quality of cooperation for service innovation among different parties within the organisations</td>
</tr>
<tr>
<td>10. Did the organisation introduce any new or significantly improved service in mental health sector?</td>
<td>To examine the venturing objectives and entrepreneurial activity of the hospitals, as this would show whether there is a linkage between service innovation and the entrepreneurial initiatives of the firms</td>
</tr>
<tr>
<td>11. How many new services did you introduce last year?</td>
<td></td>
</tr>
<tr>
<td>12. How and to what extent has your service products changed during the past 2 years?</td>
<td></td>
</tr>
<tr>
<td>13. Does the organisation have a plan for the extension and evolution of its services?</td>
<td></td>
</tr>
<tr>
<td>14. Where did the concept of developing new services come from? (existing customers, new customers, market research, always part of the plan?)</td>
<td></td>
</tr>
<tr>
<td>15. How would you evaluate the coordination among people and departments throughout the new service development process?</td>
<td></td>
</tr>
<tr>
<td>16. Will you please describe the venturing and entrepreneurial activity in the organisation?</td>
<td></td>
</tr>
<tr>
<td>17. What are the hospital’s venturing objectives?</td>
<td></td>
</tr>
</tbody>
</table>

228
18. How are entrepreneurial opportunities identified, evaluated and selected by the organisation?  
19. How does the organisation encourage and support entrepreneurial activity? How does recognise and reward innovative efforts?  
20. What preliminary market assessments occurred before any investment was undertaken? (market research, market segmentation)  
21. Is there a clear idea of the type of information to be obtained through market assessment?  
22. How much time and effort is spent in conducting interdepartmental meetings to discuss market trends and developments?  
23. What type of relationship does the organisation have with its customers?  
24. Is there an adequate process to track and respond to customer queries and complaints? If so, does management get an up to date of the status of complaints?  
25. Is there a robust mechanism to integrate the views of customers into the service planning process?  
26. How much room is there for customisation and judgement on the part of service provider?  
27. Please determine the ways by which the hospital can increase customer involvement in its innovative activity.  
28. Are there measures of customer satisfaction that you use to improve your services?

To explore how entrepreneurial opportunities are identified and evaluated by the case organisations and how they encourage, support, and reward such initiatives.

To explore whether the hospitals gain knowledge and inputs from the market as well as how they assess the opportunities before any investments take place.

to examine the amount of time and effort that is spent in interdepartmental meetings regarding market trends and developments.

To explore the type of relationship between the case organisations and their customers.

To investigate whether a process, and/or a mechanism is used by the hospitals to respond to customer queries and incorporate them into the service planning process.

To explore whether there is flexibility on the part of the service provider.

To explore how the companies increase customer involvement and present whether measures of customer satisfaction are being employed for improvement.

### Table 6.2 Set of questions for medical staff

<table>
<thead>
<tr>
<th>Questions</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are adequate tools and processes used to generate opportunities for product development?</td>
<td>To explore whether the hospital uses proper tools and processes, leading to the creation of opportunities for product development.</td>
</tr>
</tbody>
</table>
| 2. Does the organisation do enough to create:  
  i. A culture where continuous improvement is regarded as a norm?  
  ii. Incentives for staff to identify and act on opportunities for improvement? | To examine whether there is a business culture that promotes innovation and acts on opportunities for improvement. |
| 3. What do you think is the role of the medical staff in promoting the internal innovation process? | To understand how medical staff perceive themselves in the promotion of the innovation process. |
| 4. Did the organisation introduce any new or significantly improved service in mental health sector? | To explore whether the hospital has developed or improved services in its mental healthcare division. |
| 5. How many new services did the hospital introduce last year?  
  6. How and to what extent have your service products changed during the past 2 years? | To show whether the case organisation has developed and/or improved its services the recent years. |
| 7. How would you evaluate the coordination among people and departments throughout the new service development process? | To investigate the level and quality of cooperation for service innovation among different parties within the organisation. |
| 8. Is there an adequate process to track and respond to customer queries and complaints? If so, does medical staff get an up to date of the status of complaints? | To investigate whether a process, and/or a formal method is used by the hospital to respond to customer queries and incorporate them into the service planning process. |
| 9. How much room is there for customisation and judgement on the part of service provider? | To explore whether there is flexibility on the part of the service provider. |
The in-depth elite interviews were conducted with top management executives and hospital managers of the case hospitals to further understand and present the innovative and entrepreneurial activities of organisations. The data collection employed content analysis to allow categorisation into four groups, as mentioned in previous sections. Below, the analysis of the data of those four groups is conducted, starting with the innovation activity of the case organisations and the role of patients and then describing the health service development process. It follows the analysis of the companies’ entrepreneurial model and finally, the customer involvement in the health service innovation is discussed.

6.2 Innovation development and the role of patients

This section examines the hospitals’ innovation activity and the role of patients in service development initiatives. The factors that encourage innovation as well as the tools that are used for new service development are explored below among other issues, such as organisational structure, entrepreneurial activities, and customer orientation.

6.2.1 Dynamics affecting innovation in mental healthcare

What is true for every business applies to the private healthcare industry as well. Healthcare providers must be competitive compared to others operating in both the private and public sectors. As it was highlighted by the top executives of the case hospitals, it is essential to add new areas of service, as private healthcare is a continuously developing sector, so businesses must be competitive, finding new sources of revenue. Healthcare companies should therefore be innovative in dealing with both doctors and public. It has been widely accepted in the literature that innovation is intertwined with and perhaps identical to the concept of entrepreneurship (see Sections 4.2.1 and 4.2.2). Innovation offers competitive advantage and the healthcare area is open to this. For example, technology is highly involved in healthcare, so it is relatively easy for firms to renew their services. On the other hand, it has been indicated through the interviews that quality is a key element in which companies compete in the healthcare industry, thus quality improvement of services is another key issue. The chairman
of the Saint Irene hospital clearly emphasises that “to improve your services, you need to be innovative, monitor developments and offer better products.”

Nevertheless, there are a number of factors, internal and external, that either predispose or discourage companies to be innovative. Participants argued that several internal factors encourage hospitals to seek access to innovation: evolution of technology; enhanced quality of the service offerings; the need to remain competitive and have additional revenue from different sources in a time of crisis. For example, the managing director of Thermaikos hospital believes that the incentive for development is the main factor that motivates the unit to be innovative, while on the other hand an economic crisis affects innovative activity. For instance, insurance funds significantly delay paying off their obligations to hospitals, creating liquidity shortage and growing uncertainty. Likewise, the hospital manager of Castalia argues that the basic internal factors that motivate the unit to be innovative are the implementation of good practices that save labour hours, the cost of raw materials/supplies, and increased employee productivity. In addition, the attitude of managerial and scientific staff towards innovation and the evolving needs of patients constitute those internal factors that motivate Galini hospital to be innovative, according to the response of the CEO.

In contrast, extraneous factors such as legislation – the operational framework of private hospitals - as well as economic and social factors usually dishearten businesses that operate within the Greek business environment. This view is strongly supported by all contributors in the research, as legislation and the current economic conditions are negative for innovation. For instance, the chairman of Saint Irene hospital and the hospital manager of Eleftheria hospital state that the operating framework, set by regulatory mechanisms in state laws, changes frequently in Greece. In particular, a series of new measures, regulations and reforms introduced by the government, since May 2010, alter the context for action. The business development manager of Eleftheria hospital is consistent with this viewpoint reporting that law is labyrinthine in the healthcare industry. Separate legislation for primary and secondary care, and separate for each sub-sector. In such a context, it is not easy to integrate innovative actions, so legislation usually does not push for innovation: rather the opposite. Likewise, the hospital manager of Galini explains that legislation completely determines the stance of the hospital.
As regards the economic factors, many participants argue that, especially in the last decade and more, businesses that operate in Greece had benefited from the good economic climate and from easy credit; people could spend more easily than today. Other than that, both the chairman of Saint Irene hospital, and the hospital manager of Eleftheria hospital argue that economic factors influence innovative activity only in relation to whether it is costly, i.e. the cost of developing an innovation or the motivation required. However, an innovative activity is not always costly. Furthermore, social factors benefit innovation but do not bring about a commensurate financial result. Participants responded that they affect the mental healthcare sector, as health is the sovereign good for people. Therefore, hospitals cannot be callous, but must show social awareness through their social responsibility programme. The chairman of Saint Irene hospital characteristically stresses that “the objective of Saint Irene is to help people in need through innovative ideas and actions and the result of this assistance is financial gain.” However, the business development manager of Galini reports that social and economic considerations often constitute barriers to the achievement of new targets.

6.2.2 Applied mechanisms for service innovation

It seems that only two of the case hospitals employ tools and mechanisms for service innovation. For instance, the director of quality of Saint Irene described the use of a management information system (MIS), which provides data that help the administration to assess the situation of the company and see areas that need improvement. This often leads to new services and new sections that consolidate the company within the healthcare market and increase its turnover. Such systems analyse customer data and medical records, reporting, scheduling, billing and financial data. Each of these elements play an important role in the treatment, outcomes’ assessment, and programme evaluation of the health organisation. More specifically, a management information system provides access to clinical information for the service provider, increases the availability of clinicians to patients by reducing the paperwork, and by improving the workflow process. Integrated patient information can also be viewed, enhancing programme evaluation and developing long- and short-term goals to improve the quality of care. Similarly, such a system helps the company to reduce the amount of time spent on handling, storing, and retrieving records, allowing staff to focus on the quality of the delivery of care. In addition, MIS improve the clinician’s ability to schedule, plan, and
document the delivery of services, creating a longitudinal view of services for staff and external agencies. From a strategic management perspective, MIS enhance organisations’ ability to plan and implement management decisions, impacting the quality of care, service delivery, and staff development initiatives. For example, a MIS can help a mental health service provider to identify potential needs that could be fulfilled by the development of a new service for the outpatients, which is delivered through the internet. A series of such services has led to the development of the department of tele-care and innovation at St. Irene.

Furthermore, the business development manager of Eleftheria mentioned that the marketing team is responsible for carrying out regular market researches to be acquainted with the needs of customers, the state of the competition, and other important information that helps the hospital take appropriate decisions. What is more, various reports on industry or employment published by consultancy firms complement the information required. Furthermore, the hospital manager and the scientific director of Eleftheria note that the hospital has questionnaires for service users from which useful conclusions are drawn for service development and improvement. Apart from the tools used at Saint Irene, informal processes are followed in new service development. Saint Irene hospital follows a four-step process: concept, design, implementation, and evaluation. Ideas usually come from the continuous monitoring of developments in the industry and the needs that arise. Later, ideas are evaluated and priced. Sustainable ones are adopted and others that may not be viable or profitable but confer prestige are categorised as such. In such cases, those ideas that seem to create no significant negative effects are approved.

On the contrary, Thermaikos hospital does not use proper tools not follow well-structured processes. The manager mentions that they have not promoted initiatives that could deliver rapid growth and believes that they should follow different strategies prior to reaching crisis. Likewise, the responses from Galini hospital indicate that no specific tools are used for the development and improvement of new services and that the procedures in fact adopted here are informal. Similarly, executives from Castalia hospital indicate that no adequate tools and procedures are used to develop or improve services as well. However, the quality and medical services manager states, “services are reassessed and generally, positive actions are being promoted, improved and developed.” One of Castalia’s goals is to cultivate a
culture where continuous improvement is regarded as a rule. All interviewees were positive on this and the manager added that there is daily monitoring of services, while the administration is open to positive initiatives. Similarly, the psychiatrist and scientific director of the Thermaikos hospital argues that they also try to set up procedures that would improve services, but this effort is still in its infancy, whereas the director of quality notes that they also aim to establish a culture by which continuous improvement would be considered as a model, with constant communication with staff and frequent references to potential benefits. Nevertheless, none of the scientific personnel shares this view, replying that in practice the creation of such model cannot be realised. It is noteworthy the response of the social worker of Castalia, who stated that “A clinic should be primarily an example to its personnel and relatives and then to society”. On the contrary, respondents from Galini agree that the administration of the hospital seeks to establish a culture in which continuous service improvement is considered as a norm. Following a similar approach, both Saint Irene and Eleftheria hospitals attempt to establish a culture by which top executives solve problems and develop ideas based on a model of growth and innovation. This approach works well and transfers knowledge from managers and supervisors to the remaining staff.

Yet, it is worth noting the difference in responses as regards the incentives given to staff to identify shortcomings and present ideas for improvement. The participants of Thermaikos state that the hospital does not offer incentives to employees, even though they are in favour of such action and recognise its value. In fact, a pathologist claims that administration drives staff to exhaustion. In contrast, half of Castalia’s respondents answered that incentives for improvement are provided, with the social worker indicating that the medical staff is regularly informed on how to address illnesses. The other half, including the quality and medical services manager, do not consider themselves as highly motivated or that staff is sufficiently informed to act appropriately. Likewise, the medical services manager of Galini stresses that the proper mind-set is established through regular meetings, immediacy of communication from the lowest to the highest level and continuous assessment. He also claims that there is no need for other kinds of incentive, which “…have proven to be of reduced efficiency and duration.” In addition, it appears that both Saint Irene and Eleftheria hospitals work on the establishment of a culture for continuous improvement, encouraging employees to suggest new ideas for diversifying its services and enhancing quality. The medical and
nursing service manager of Eleftheria stated, “The hospital aims to develop a labour culture where everyone can create, grow, and feel proud of working here.” According to the hospital manager, there are three types of incentives in such cases. First is the moral reward, where the directors of hospitals have to motivate staff to contribute, with new ideas, to the company's growth. Second, there is a financial reward as a bonus for success and overall effort, and finally, institutional rewards when employees get promotion according to their performance in relation to the needs of the company. Nonetheless, the medical services director and the pathologist of Saint Irene highlight that the hospital mainly prompts and expects high officials (e.g. doctors, managers etc.) to present new proposals, business ideas, and investments. Incentives for other staff are usually designed to encourage adoption and implementation of the new development.

Still, most of the scientific staff note that there are incentives and rewards that are associated with working performance, despite the fact that a minority noted the absence of such actions. The nursing service director of Saint Irene and the business development manager of Eleftheria answer that no such incentives in fact exist and the former mentions, “The hospital has no executives who are motivated towards improving. There are no incentives to personnel and the general economic climate does not help at this time.”

6.2.3 Service users and innovation process development

The manager of Thermaikos hospital argues that many patients have difficulty in indicating their desires; therefore, the hospital attempts to communicate with their relatives. However, customers’ requirements are taken into account in innovation strategies of hospitals, enhancing their intention to provide quality health services. Specifically, Castalia’s hospital manager argues that customer requirements are taken into account to the point where they can meet and be applied to other customers’ conditions. However, the medical services manager of Galini hospital argues that there is still room for improvement regarding patients’ contribution to the development of new services. Yet, the views of participants were divided as regards the contribution of patients in developing new services. The medical services manager of Thermaikos reports that few patients may share their opinions, make suggestions, or discuss their needs. Similarly, the scientific director explains the low social level in the clinic, which complicates patients’ integration into development programmes. On the other hand,
there are few patients and relatives who are friendly, have good living standards and assist the hospital. The psychologist of Thermaikos clearly argues in favour of patients, saying that these people can communicate their opinions, especially if aided by special programmes for expression. Likewise, the social worker discusses that growth occurs through the critical views of patients, since they are those who benefit, and notes, “Unless we start by being enlightened enough to listen to them and hear ideas, I think we will lose the game.” Similarly, the scientific director, head of the nursing service, and the other medical personnel of Galini (i.e. pathologist, psychologist, occupational therapist, social worker) argue that patients may contribute significantly to this process. Specifically, the psychologist clarifies that perhaps it could be done, up to a point, especially for something additional or different. “I think they could contribute to the development process, if first they expressed their opinion about the services provided,” she adds.

It is important to note that the primary client in the Greek healthcare system is the associate doctor. Patients are ‘secondary’ direct customers. Private doctors refer their patients to private hospitals as an alternative, quality solution. Considering this, the chairman of Saint Irene hospital responds, “we are always open to views and novel ideas from customers. These are the main driving force even in strategic moves, such as creating a new unit or a new service.” The market requirement (e.g. doctors, patients, etc.) and the development of medical science are the factors that impel the acceptance and integration of innovation within healthcare industry firms. The director of quality explains that Saint Irene has developed customer service departments for patients and relatives in every hospital unit. “We consider customers’ complaints or claims so as to improve our services,” she adds. Still, top executives of both Saint Irene and Eleftheria hospitals support the opinion that patients may contribute and should be involved in the process of developing and improving the accommodation/residential services, and rather less the medical methods. According to the medical services director of Saint Irene, “patients can contribute to innovation management and not to innovation acceptance or implementation. As regards medical services, doctors are those who decide on and follow scientific rules and developments.” This is also supported by both the nursing service director of Saint Irene and the medical and nursing service manager of Eleftheria hospitals. However, the nursing service director of Saint Irene hospital responds
that in mental health services “we hear carefully what our patients have to say about their treatment.”

The scientific director and the head of the nursing service of Thermaikos argue, however, that no opportunity is given to patients to express their aspirations because no such culture has been developed by the hospital that will take an interest in their deeper needs. This is consistent with the views expressed by both administrative and scientific staff of Castalia that patients could contribute further to the process of service development. The patient services and admissions manager stresses that those patients who express their demands already participate in the process. The social worker also argues, “Contact with patients is a continuous learning process that helps everyone to improve.”

6.2.4 The role of hospital executives and scientific personnel in innovation process development

The role of top executives in promoting internal innovation process is fundamental, as they govern the progress of innovative action and rectify any deficiencies. Every manager is responsible for promoting solutions and bringing forward ideas for innovation. The hospital managers of the case organisations have supported that top executives and scientific personnel, design and foster innovation, mentioning that their role is critical, as these are those who develop ideas and determine the method of implementation. This is consistent with the responses of the interviewees. “We want the organisation to operate within a decentralized model. Managers play a key role in the promotion of solutions and innovation”, the chairman of Saint Irene hospital states. Likewise, the medical and nursing service manager of Eleftheria and the medical services director of Saint Irene argue that the role of top executives is the most important in promoting the internal innovation process. There are those who push for a decision to be taken, for an innovative activity, or for an innovative investment to be made. If executives do not give support to the suggestions of physicians and patients, then no proposal will proceed to the next stage. They should also give opportunities to staff and encourage them to contribute to innovation efforts. The chairman of Saint Irene emphasises the role of top executives, stating, “Managers and scientists are at the forefront of the innovation process. Their role is crucial to both organisation and implementation of innovation.”
Moreover, the scientific directors, psychologists, and heads of the nursing service of the case hospitals seem to agree, pointing out that the role of scientific personnel is critical, as they facilitate the creation and promotion of new ideas and the implementation of decisions. Equally, the pathologist of Castalia and the occupation therapist of Eleftheria hospital argue that medical staff, usually, start implementing an innovative action, then, along with other executives, monitor its progress, and make the necessary corrections. However, the scientific staff of Thermaikos hold a different viewpoint and acknowledge that the voice is unheard; there is scepticism from a part of the administrative staff, some of whom prefer to support the existing order. Consequently, it seems to be a diverse point of view. Responses vary and are of particular interest regarding the role of top executives and scientific personnel in promoting innovation. Participants of Castalia hospital agree that staff play a determining role as they promote and reassess innovative services. Both the scientific director and the pathologist state that the workforce is the driving force behind any attempt to innovate, while the social worker notes that staff should keep up-to-date and adopt innovations to maximise their efficiency. Similarly, the psychologist states that everyone who utilises their own knowledge seeks to improve and to promote new ideas to enhance the operation of the clinic. Based on these arguments, the psychiatrist proposes certain actions to set the framework for the development of new services:

- Understanding, recording and classifying patient needs;
- Cooperation between different disciplines;
- Organisation of actions aiming at better provision of services;
- Supporting relatives of patients;
- Supporting and preventing staff burnout.

However, it seems that there is room for improvement regarding the participation of the scientific staff in fostering innovation. The director of quality of Saint Irene states that the role of physicians should be more decisive, while the head of the nursing service of Eleftheria emphasises that the administration should develop a more fruitful cooperation with them.

Furthermore, it appears that the case hospitals treat failure with clemency in an attempt to be innovative. This emerges from the response of the chairman of Saint Irene that “even the best business plans may prove to be erroneous and fail. The point is to learn from
your mistakes and improve.” Management teams appear not to penalise unsuccessful attempts, while assessments are intended to enhance the learning process. The aim is to gain knowledge from such experiences, to improve the hospitals’ operations and procedures. This is verified by the psychologist of Castalia, who claims that efforts are assessed and new ways of improvement are sought. “Failure is the beginning of all subsequent efforts to improve and progress,” she adds. In line with this, other executives mention that there are times where the performance of an investment has been overestimated or seems to have significant short-term benefits only. In such cases, failure is analysed to prevent recurrence. For instance, Saint Irene appears to follow proper procedures to analyse innovation prior to the implementation and commercialisation stages. Similarly, the patient services and admissions manager of Castalia argues that failures are permitted when a service is under construction or jointly developed. Equally, Galini hospital seems to avoid condemning less-successful attempts if these were designed to improve and develop services. In cases where the outcome is other than the expected, an assessment identifies errors and omissions. The medical services manager underlines that the aim is to gain knowledge for future actions - to learn from mistakes. Similarly, a psychologist notes that failures have been observed in those cases where different techniques and personalised services were applied to patients. Sometimes, the result is not the best possible. In such cases, the hospital staff tries to gain knowledge to avoid similar mistakes in future. Nevertheless, the scientific coordinator and psychiatrist states, “Punishment does not exist. Still, innovation is not our top priority.” Shortcomings are likely to be penalised, however, when an attempt was made individually without the approval or consent of the supervisor. There may be penalties, for example, in cases of omission, the medical services manager of Thermaikos said.

6.2.5 Organisation, structure and entrepreneurial growth in mental healthcare

The main goal of the case hospitals is to integrate many innovative ideas, resulting in their strategic growth. However, the views of participants are ambiguous. Some defend the organisation and the structure of their hospital in implementing innovative actions, while others claim that there is room for improvement. The hospital manager of Castalia believes that the stimulus of growth could help mental health hospitals become more innovative, developing new services and approaching new markets, resulting in an economic return. In
particular, Castalia hospital could save resources, labour hours, and materials for the development of innovative services if it adopted better organisational and functioning systems. Likewise, the business development manager of Thermaikos argues that the stimulus of growth significantly helps the hospital’s innovative activity, resulting in new groups of patients. Better organisation and enhanced structures are required for the hospital to proceed to the development of new services. “This is somewhat difficult to achieve at this point in time,” he adds. Furthermore, the chairman of Saint Irene and the hospital manager of Eleftheria believe that their organisations have been set up in such a way as to implement innovative activities straightforwardly by adopting policies and idea generation and sharing processes that contribute to organisational renewal. Similarly, the director of quality of Eleftheria maintains that the organisation and structure of the hospital assist innovative activities to thrive, giving room to employees and executives to express themselves and take initiatives. For instance, peer workers showed willingness and were effective at connecting people with mental health problems with services. This leads to the outcome that having the right number of staff trained, in the right way, can enable innovations. The continuous need for innovation advances the solutions of problems, considering that new challenges emerge that were not before encountered. It becomes evident that many of the problems in complex open systems, such as health and social care, can be solved by new solutions and innovative thinking.

In contrast, many other respondents (i.e. nursing service director and occupational therapist of Saint Irene, head of the nursing service, psychologist and social worker of Eleftheria) stress that the organisation and structure of their hospitals do not help, because of mediocre cooperation between departments and a lack of necessary departments, e.g. a special committee for innovative investments. Nevertheless, the CEO of Galini hospital holds a different point of view, explaining that organisation and structure have no value, as they are variables that may, at any time, be redefined by administration to point in the desired direction. Rather, an essential characteristic of this unit is the direct and continuous communication between administration, employees, administration, and patients that builds the tenacity and dedication needed to achieve the desired result. In addition, necessary enhancements are made directly without adding to bureaucracy. At the same time, growth is
defined as the main business objective of the hospital. Therefore, patients’ satisfaction, through the development of new services, is the hospital’s strategic plan.

6.3 Health service development

This section investigates the processes, the service improvement plans, and coordination dynamics within the case hospitals. It also explores the level of new service development within the last two years, the source of ideas for new services, and examines the strategic plan for the expansion of services within the organisations as well as the level of coordination among people and departments throughout the innovation process.

6.3.1 History of health service development in case hospitals

Although there seem to be activities and efforts toward innovation, the actual outcomes and levels of performance are low, and sometimes poor. Participants from Thermaikos hospital argue that the unit has not introduced any new or improved service in the mental healthcare market in the last two years. The hospital manager explains that the problems of the past and the current financial crisis do not leave room for growth. Similar to this viewpoint, the business development manager reports that a plan has been carried out over the last two years to improve services, upgrading hospital’s building infrastructure and recruiting qualified and experienced personnel. Similarly, Castalia hospital has attempted to upgrade and enrich its services to be creative and competitive. Contemporary facilities have also been founded. For instance, laboratory tests take place on-site for immediate handling of patients’ pathological problems and more specialist doctors are employed (i.e. physician, psychiatrist, and neurologist). Activity groups for patients have also been developed, such as construction tasks, puzzles, painting, and music, along with intensive care services and features of occupational therapy, with experimental dance therapy groups. Likewise, Saint Irene has not introduced any new services to the industry, according to head of the nursing service. Both the director of quality and the medical services director explain that the hospital’s aim is to develop within the sector in terms of both infrastructure and in the manner of providing
services. The hospital’s strategy indicates the establishment of centres for alcohol detoxification and dependencies other than non-legal drugs.²

However, Galini hospital has undertaken some initiatives for innovation. Respondents point out that Galini has introduced three new groups of services within the previous year. One new set of services is associated with activity groups. For example, excursion groups have become more frequent. Patients go out to into society to stroll, shop and do other socialising activities. Additionally, the hospital has adopted experiential psychotherapies, a new service offered by qualified staff, which involves outpatients who follow some form of treatment, but need not be hospitalised. There has also been developed a psychosocial rehabilitation service, based on regular and customised clinical and psychosocial investigation of a patient’s capabilities and needs. This treatment programme includes: individual and group support sessions; psycho-educational groups for families; groups that fight self-stigmatisation; social work with groups; a patients’ community; etc. Likewise, the scientific director of Thermaikos adds that attempts to improve service quality for both patients and employees have had effects. The social worker reveals that the hospital adopted programmes and initiatives to improve its treatment methods over recent years. For example, the presence of a social worker was established, with day-to-day contact with relatives, arranging their service books, and discussing other social matters in general. Additionally, nutrition and entertainment have been improved and creative activities have been added that did not previously exist, such as excursions by some patients to the city, painting, a newspaper, etc. Both the scientific director and medical services manager of Galini argue that the services are routinely monitored in terms of efficiency and satisfaction, and then improved. There are times where small changes lead to complete transformation of a service. As emphasised by the social worker, Galini’s services have changed significantly over the last two years. New programmes for some patient groups have been added, such as cognitive programmes for those with dementia; excursions; autonomy groups; etc. Likewise, the psychiatrist stresses that patient service and care has been upgraded.

Overall, the responses emphasise efforts for continuous improvement, however the success of disruptive innovation is questionable. This is in line with the opinions of Castalia’s

² The Greek law prohibits private initiatives in illegal substance rehabilitation.
medical personnel. For instance, the social worker notes that service quality has been markedly improved; contributing to better health for patients, while the psychologist adds that there is constant progression. The number of psychologists and occupational therapists on duty has been increased. Indeed, the psychiatrist highlights that services have changed significantly over the past two years. Integration of additional specialties has resulted in improved health for those patients who underwent psychotherapies and developed their skills.

6.3.2 Service development and growth strategies

The managing director of Thermaikos hospital reveals that there is no short-term plan for the expansion of operations or the development of services. He says that, at this moment, they are addressing internal issues and trying to survive, overcoming the crisis. As regards medium-term planning, there are only thoughts and ideas, which mainly originate from existing customers and the hospital’s vision. On the other hand, the CEO and the hospital manager of Galini, and the business development manager of Castalia report that both hospitals have their own plans for the growth, despite the fact that it is still at the stage of idea generation and organisation. On one hand, the hospital and business development managers of Galini argue that every component of the strategic plan is designed considering both internal and external factors (social, economic, legal etc.). The ideas for new services arise from developments in science; existing and potential patients; medical staff; information on what happens in other structures, and any changes in the legal context. On the other hand, the business development and quality and medical services managers of Castalia state that ideas for new services derive from the market, discussions with customers, and staff initiatives. Similarly, several attempts have been carried out by Saint Irene and Eleftheria to unlock this sector, either by developing activities beyond the clinics by or using experts, occupational therapists and psychologists, to provide new services and bring alternative forms of engagement for patients. As both hospitals are relatively new units, it seems that health services have not changed considerably over the past two years. However, the medical services director of Saint Irene and the business development manager of Eleftheria explained that efforts are being made to increase the number of units-departments (geriatric, rehabilitation, etc.), and expand the range of provided services. In particular, the existing units
have introduced a number of new departments and services, updated their equipment, and developed new treatments. In the case of Saint Irene, the scientific director and the medical services director explain that great importance is given in establishing new open structures that will reintegrate patients into society.

### 6.3.3 Intra-organisational collaboration dynamics for service innovation

Although many of the case hospitals appear not to have an expansion and development plan in place, the executives of Saint Irene explained that their strategy derives from market awareness and demand for health services. The ideas for such programmes come from the hospital’s executives, associate doctors, competition, and market research. Initiatives usually come from unit heads, who are responsible for the development, or doctors who will introduce a new idea. Comments and suggestions by customers also play an important role. As chairman reports “(customers) always have their share in determining the adoption of new procedures.”

What is more, many respondents agree that the coordination between people is good in the case hospitals. For instance, the psychologist of Galini hospital emphasises that effective coordination between departments is essential when developing a new service and everyone must contribute to the success of the new offering. Similarly, the pathologist of Thermaikos hospital states that there is good communication and cooperation among medical staff. Nonetheless, the social worker and psychiatrist argue that there are some difficulties in coordination and suggest the development of a team that will be responsible for supervising innovative actions. Equally, the managing director explains that there were deficiencies in the organisation and implementation of new projects; therefore, there is room for improvement. Similarly, most of the participants from Galini declare that the coordination between departments of the hospital is moderate and there is significant scope for improvement. The physician explains that they face certain difficult issues in cooperation; therefore, they call regular meetings among medical personnel. Likewise, the chairman of Saint Irene adds, “The management team is responsible for the coordination and management of this hospital, but we are undergoing intense development. We seek to solve any coordination problems that come up.” The medical services director stated that despite coordination among the employees of the hospital, many issues arise between hospitals’ staff and the associated
doctors. This constitutes a constraint on the introduction of new actions. Similarly, the business development manager of Eleftheria noted “communication and willingness to cooperate deteriorates over time. Especially during this difficult time, confusion and often misinformation spread by company management is noted.” Likewise, the scientific director and the head of the nursing service consider the coordination among people sometimes as inadequate and explain that there is difficulty in communication and cooperation. The director of quality and the scientific director of Saint Irene also argue that the powerful bureaucracy hinders innovation. It seems, however, that there is considerable disagreement on this issue among top executives, as the chairman of Saint Irene and the hospital manager of Eleftheria agree that one of the most important investments in their units is to balance and develop strong cooperation between departments and units. The nursing service director of Saint Irene states, “we often adopt innovation and place it where we are already ahead. This leads to an enhanced management of innovation and concepts, given that the synergy of units works.” Along the line, the psychologist and the occupational therapist of Eleftheria claim that there is good coordination, particularly between the teams in the process of developing or monitoring the new services.

On the contrary, participants from Castalia agree that coordination among people and departments throughout the process of developing new services is advantageous. It emerges that there is cooperation and willingness for self-improvement and development. There is also an exchange of views between heads of departments on a weekly basis; discussions are followed up in monthly executive meetings to define further actions. “This system functions sufficiently well,” the hospital manager says. Nonetheless, the psychologist points out that while coordination is good, additional effort is needed to promote those new services.

6.4 Corporate entrepreneurship and growth of case hospitals

This section aims to describe the hospitals’ entrepreneurial activities and objectives. Additionally, it investigates how entrepreneurial opportunities are identified, evaluated, and selected as well as how the management teams encourage and reward innovative efforts.
6.4.1 Corporate venturing and business prospects

Thermaikos hospital has plans for growth, i.e. development of new services and creation of new business units. However, the hospital manager underlines that the development of the unit depends mainly on the decisions of the top-level management and owners of the hospital. He appears to have no sufficient information about the hospital’s entrepreneurial model and new business development initiatives. He clearly stated, “I believe that there are opportunities for growth, but we cannot ignore the fact that the top management team decides about the next steps of this unit. I am not certain that they have some concrete plans for growth. I will share my thoughts about how to tackle the crisis, and reach the break-even point at the next annual meeting.” It emerges here that, on one hand, the hospital manager does not have regular communication with the top executives, which limits his operational ability to apply the decisions, and, on the other, this lack of communication seems to act as a barrier for plans development and sharing. However, at this moment, the management team seems to pay more attention to deal with the crisis with existing offerings and resources, rather than developing new ones.

As for Castalia, its entrepreneurial model appears to be based on the demand-led provision concept. This means that the organisation explores opportunities that emerge from the requests of customers or doctors. One example is when the hospital created a new unit for the entertainment of patients, which was a wish of both doctors and service users. Additionally, the management team of the hospital explores opportunities in areas that are unexploited so as to lead the initiatives and fill the market gap. As the hospital manager points out, “The business model of the hospital is to develop mental health services in regions that there is formed request, but there are no corresponding structures to meet that demand”. Likewise, the entrepreneurial model of Galini focuses on the development of services and business units that will cover the needs of the maximum number of patients. The goal is to expand its business to cover areas in mental healthcare that are still unexploited, by developing a network of small units in the region that will provide primary healthcare services for mental patients. According to the CEO, “The overall aim of the hospital is that patients are treated and helped for their acute problem up to their reintegration into society.” Following the same rationale, the chairman and the medical services director of Saint Irene hospital
explain that primary care is to be developed so that mental patients can be treated from the beginning of the illness until their reintegration into society.

Additionally, the director of quality argues that entrepreneurial activity is encouraged by the organisational structure of the hospital, mentioning that there is a development team, which is responsible for seeking opportunities for business expansion, finding suitable areas for either establishing new units (depending on local needs), or acquisitioning other health facilities. Similarly, the entrepreneurial goals of Castalia are to expand its services into other sectors of healthcare, i.e. rehabilitation sector, and also develop a small network of primary mental healthcare settings that will cover the needs of the wider region. Moreover, as the business development manager emphasises, “Growth will come also through the satisfaction of our customers, who will choose and follow Castalia in its next entrepreneurial initiatives.” Nevertheless, it is noteworthy that the business development manager of Thermaikos answered negatively to the questions that regard the hospital’s venturing objectives. He appears not to be aware of the venturing objectives of his unit, mentioning that it is the owners who set out the goals. He added, “I am ready to submit my opinion whenever they call me to discuss about the next steps of the hospital. Then, I will take today’s data into consideration and develop proposals for discussion.” Similar responses derived from the executives of Eleftheria hospital. They note that among the key goals is to equip the current unit with a diverse range of services for mental health service users, attract more customers for both in-house and outpatient care, and find ways to tackle financial issues related to shortage of financial resources. The business development manager characteristically mentioned, “We first need to work with what we already have, before thinking to expand our operations. The current times do not allow us to implement our growth strategies.”

6.4.2 Exploitation of entrepreneurial opportunities

Companies should have their eyes look towards future, as today’s entrepreneurship is not successful without traits of innovation. Many respondents have reported that innovation is an essential element of entrepreneurship. Saint Irene’s chairman noted, “entrepreneurship without innovation, is entrepreneurship of yesterday.” This is consistent with the viewpoint of Castalia’s hospital manager, who adds, “This is the motivation that guides us towards innovation. We seek to exploit opportunities and innovate in areas that others have not
reached yet. *We conduct market research to identify the need and assess how this need is met. Following this, we consult industrial reports that show which sectors will continue growing in the near future.*” Entrepreneurial opportunities are identified by market research and evaluated by hospitals’ executives, doctors, and management teams. They decide which opportunities worth exploring according to the needs, the competition, and the current economic situation. Hospitals’ executives appear to encourage innovation by allowing stakeholders to take initiatives for growth. For instance, the top management team of Galini hospital allows associate doctors to lead and invest in an effort, providing the necessary administrative and financial support. In this case the exploration and exploitation of external networks guide company’s innovation efforts in collaboration with other local and regional partners. Entering networks helps entrepreneurial actors to acquire information that is relevant and effective for them. The level of competitiveness developed within a region affects both the strategic decisions and the overall innovation performance of the actors. Resilient networks contribute significantly to the innovation performance of the region by creating new sectors that promote the development of linkages of knowledge, skills, and input–output between the actors. Companies’ networking stress and the external resources provided by collaborators advance the internal, external, and relational dynamics of the actors. The executive of Galini supports the idea of firms’ individual capacities development simultaneously with the resources provided by the network as well as by the agents that set linkages between the actors of the external networks. The strategy of individualistic but also collective growth advances the levels of innovation performance, not only for the individual firm, but also for its immediate knowledge partners. In light of this, a key idea may be that heterogeneity could be understood as a mind-set and practice where complexity and diversity are leveraged strategically in a manner that promotes sustainable entrepreneurship.

Nevertheless, processes exist in the case of Galini hospital before any investment takes place. Prior to making an investment, scientific evaluations of innovation are conducted to show how and to what extent the prospective initiative would provide a solution to a therapeutic or a diagnostic problem. Secondly, the number of possible incidents that can be served by this innovation is being estimated. Thereafter, a business plan is developed to show whether this initiative is viable in reference to the prices and the cost of the investment. Likewise, the management team of Saint Irene takes the economic and market data into
account when a new investment is considered and discussed. Each investment, however, requires time for data collection. The medical services director states that, when developing a new service for example, usually a few months are required for data collection, assessment and decision–making. On the other hand, when the hospital establishes a new unit, the procedure is clearly more demanding and time-consuming, as external parties contribute to the development process, of the new initiative.

From another perspective, the hospital manager of Thermaikos seems to have a passive role in developing business plans and in participating in the decision-making process. In this case, he does not seem to be certain about how entrepreneurial opportunities are identified, evaluated and selected in Thermaikos hospital. He argued, “There are several ways to identify entrepreneurial opportunities, such as by eavesdropping the market, or by involving stakeholders in the development process, etc. Again, it is not my role to evaluate and decide which of those opportunities deserve to be investigated. My role starts at the point where the management team will call me to share my opinion or to implement several actions that others’ have decided.” Nevertheless, the management of Thermaikos provides the necessary time and space to employees to share their views and suggestions concerning hospital’s operations, but does not implement any processes that would reward such efforts. The hospital manager reports, “Regular discussions take place within the hospital, both with the medical staff as well as with patients and relatives. My role is to hear everyone and then I keep those that I consider important and viable at the time of discussion. I also keep notes about suggestions that could open opportunities for growth in the near future. The management team is always interested in and encourages medical staff to participate in discussions regarding hospital’s operations and development.” As regards recognition and rewarding, it appears that there are moral rewards to innovative employees in Castalia, Saint Irene, Galini, and Eleftheria, whereas there is room for improvement in Thermaikos. On one hand, executives of the hospitals noted that they recognise innovative efforts by rewarding employees for their ideas and the additional work they have to carry out, by offering financial bonuses, opportunities for institutional promotion, etc. On the other hand, Thermaikos’ director of quality notes, “Even though we listen to what our stakeholders have to say, we have not adopted any official process that would promote, encourage, and reward the
participation of, let us say, patients or employees. I think that we could be in a better position than where we are today, in terms of recognition and rewards for innovative efforts.”

6.5 Patient involvement and health service innovation

Customer involvement in new service development is being examined in this section. The relationship of the hospitals with their customers is analysed. This section also discusses whether methods, processes, and tools for customer involvement are used. In particularly, this section discusses the tools that are used for market assessment as well as the type of relationship the hospitals have built with their customers. The methods and mechanisms that integrate customer complaints into service development process and the level of patient involvement in the hospitals’ innovative activity have also been examined.

6.5.1 The impact of market assessment on service development

Market research is a daily, open process in Thermaikos hospital. “We listen to the market, monitor the developments, and obtain information about the moves of competitors to have our store of information filled for any emerging project. But at this point, there is no specific plan for the future,” the hospital manager explains. He also states that decisions about the course of the hospital are taken by his superiors and therefore considers that his role is complementary to decision-making and executive to decision implementation. On the other hand, in Castalia hospital, estimates occurring prior to any investment are from market research (i.e. whether current demand is met or whether there are further requirements for innovative offerings). Likewise, the CEO of Galini hospital indicates that for an investment plan, they consider demographic conditions, look for appropriate scientific personnel, and evaluate the ripeness of the market. Similarly, the executives of Saint Irene seek to learn from competition. Both directors of quality and of medical services report that associate doctors usually express their requirements prior to the implementation of an investment, as they are well aware of local market needs. Despite all this, the chairman explains that the initial step is the scientific evaluation of an innovation, (i.e. whether it helps to solve a health issue, etc.). Second is an appreciation of the number of possible incidents that can be served by this investment. Afterwards, a business plan is developed based on the pricing and cost of the investment, that shows whether it will be viable. The hospital manager of Eleftheria hospital
explains that in mental healthcare, the first element to explore is whether there is sufficient number of customers-patients as well as the economic background of the area in question. The business development manager adds, “We always collect all the necessary information. We now have the experience to know what we need to know to develop new services or to establish new units.” The medical and nursing service manager notes that information is often required about local needs, competition, and infrastructure.

Furthermore, the director of quality of Thermaikos argues that market assessment is carried out by the hospital’s bodies, confessing, more or less, ignorance about the kind of information that should be obtained through market evaluation. Furthermore, the estimated number of potential patients and their needs, and their capacity to pay for these services, constitute some of the information that needs to be obtained through market assessment in Galini, so departmental meetings between management and scientific staff discuss developments and market trends. Similarly, interdepartmental meetings are conducted in both Saint Irene and Eleftheria to review developments and market trends. Firstly, the problems of the units are discussed as well as the dynamics of local competition. Thereafter, regular meetings are organised with executives and managers, discussing the progress of the units, industry developments and the firms’ positioning, suggestions for development and improvement, etc. However, the responses from Thermaikos and Castalia indicate that no departmental meetings are held to discuss market trends, but only informal discussions among hospital executives with reference to developments in the mental health sector. However, the quality and medical services manager of Castalia reports that they have a clear idea about the kind of information that should be obtained through market assessment (i.e. number of patients in the local community; need for new services; potential cost of investment; financial return; etc.).

6.5.2 Patient involvement and health service innovation in case hospitals

6.5.2.1 Patient dynamics in service innovation

The established order in Greece, regarding investments in healthcare, is medically-oriented. Hospitals maintain tight and daily contacts with physicians, giving incentives for cooperation, organising relevant events, etc. The hospital manager of Eleftheria hospital points out
“maintaining good relationships with patients, presupposes good collaboration with physicians.” As regards the relationship between the units and their customers, respondents from the case hospitals claim that the interaction is dynamic and is based on sound service provision, as they appear to choose this hospital unit to tackle their problem if they relapse. This creates a trusting relationship over the years. This is also supported by the fact that the hospital tends to operate near capacity, as the scientific director says. Administrative and medical staff promote trust as a key ingredient in the relationship with patients. Likewise, the staff of Castalia argue that patients and relatives feel quite satisfied by the quality of services. For example, the social worker reports that the relationship with them is optimal and maintained through daily contact, adding, “we provide the best return to the people we have here.” Continuous communication is carried out through doctors’ daily visits to patients’ wards, regular sessions with psychologists and psychiatrists and frequent updating of relatives (either by telephone or personal contact) about patients' progress. The head of the nursing service mentions that this everyday engagement with patients and their relatives facilitates the provision of the services that every customer needs. Furthermore, the relationship between the hospital and its customers is interactive, “a relationship of trust,” the pathologist says.

The maintenance of this relationship is reinforced by the intentions of all staff members to improve. The scientific director indicates that Castalia hospital seeks cooperation with relatives to provide superior treatment and to cure patients, and gets families involved in treatment plans. The customer relationship is maintained through the psychological support of patients, understanding of the problems they encounter, and improving their communication with staff. Following the same approach, Thermaikos’ service provision is based on human, direct relationships, and most of the staff respond. The medical services manager reports, “The hospital bases its success on this personal contact and the good provision of health services.” Similarly, the director of quality of Saint Irene and the medical and nursing service manager of Eleftheria report that the hospitals' relationship with patients begins and finishes inside the hospital and is maintained by offering superior quality. Still, the scientific director of Eleftheria notes, “the relationship with patients is professional and humane. This is also pursued by associate doctors, keeping relatives well informed.” The scientific director of Saint Irene underlines that services must be affordable to average
incomes and provided as quickly as possible. However, “there are patients, though, who do not participate; do not respond,” the pathologist of Galini hospital says. Likewise, the psychiatrist notes, “we try to establish good relationships and communication with relatives. Many of them, however, do not care.” The psychologist and social worker of Castalia stress that deinstitutionalisation is moving very slowly in Greece, so some patients have spent their entire lives in the hospital. In those cases, an interpersonal and even a kind of ‘family’ relationship have been developed. Likewise, the psychologist of Galini argues that the relationship with families is tending to improve. “We inform them about the health status of their patient and they help us to manage them. Further, the relationship with patients is good, since there is a strong effort by the hospital to meet al.l their needs.” The head of the nursing service concludes that good cooperation and maintenance of the relationship comes about through high quality services and patient satisfaction.

6.5.2.2 Patients’ insights in health service innovation

Generally, responses show that there is no adequate process for monitoring customer queries and complaints. It appears that the medical services directors and the nursing service managers are designated to specialise in customer service, being responsible for responding to patients’ questions or fulfilling their special requirements, identifying difficulties and ensuring their resolution. In addition, the hospital managers are responsible for providing solutions in other cases where major concerns are recorded (i.e. in nursing; residential/lodging services; medical errors; indecent behaviour). The chairman of Saint Irene emphasises that the hospital follows ISO standards, which lay down the functions of units, the needs, and convenience of patients, etc. In addition, associate physicians who refer patients to the hospital reflect on the services provided and then the company receives feedback, availing itself of an excellent relationship with these physicians. What is more, there is no formalised process in Thermaikos hospital for recording customer requirements. Participants mention that complaints are expressed verbally to medical staff. Then dialogue and consultation are used as tools to solve the problem. In most cases, it seems that the administration of the hospital is being updated. Similarly, the scientific director of Eleftheria reports, “proper procedures are not followed, as there is no entrepreneurial culture which might create the necessary infrastructure for taking seriously the complaints of patients.”
Equally, the social worker of Galini reports, “The administration of the hospital is informed and the appropriate resolution process is provided, yet there is no formal tool, or procedure, by which the opinion of patients would be considered in the development of new services. Neither is a mechanism used to incorporate the views of customers into the process of designing new services. Only informal meetings among departments are conducted to discuss such issues.”

Nevertheless, the medical services manager indicates that there are thoughts of adopting such a tool. For instance, there is a printed form in Saint Irene hospital, which is given to patients to assess all stages of the provided service, i.e. quality of accommodation and food, staff behaviour, a record of any complaints or suggestions. Those forms are collected then processed, and the rating is monitored over time. Thus, the level of operation of the unit is revealed, with the scope for improvement and growth potentials. Notwithstanding, no such tools seem to have been adopted by the other case hospitals. Yet, as mentioned by the scientific director of Saint Irene, “there is doubt about such actions in Greek society and unfortunately, only a small number of patients complete the assessment leaflet.” Furthermore, the nursing service director points out that customers do not usually participate in filling in questionnaires. Therefore, the hospital manager explains that there is a pertinent instruction to the staff to interact with customers. Yet, he stresses that people who reach a health facility usually experience a health issue, and therefore are not in a suitable mood or would not patiently share their thoughts.

Consequently, patients informally express their opinions and make comments to psychologists and psychiatrists in most cases, and the administration of hospitals is then informed in all cases. It appears that no formal processes or mechanisms exist in the case hospitals to monitor and response to patients’ preferences. There is no official method in which complaints and suggestions from patients feed initiatives for developing new services. Both the scientific director and medical services manager of Castalia add that no formal process exists by which complaints and customer queries might prompt creation of new services. “Following their recording by the heads of department and doctors, complaints are passed on to management and appropriate measures are taken,” the medical services manager reports. At Saint Irene hospital, there is an informal process through the cooperation of the medical personnel, so that patients’ complaints may fuel initiatives that meet their
needs. The psychologist indicates, “The low performance and initiatives for service development are set out differently in each unit and are activated as based on the management team.” The hospital has not yet developed a specialised mechanism to incorporate the views of customers into the process of designing new services. As mentioned above, the suggestions from patients and physicians are discussed in regular meetings, in which top executives and the scientific director take the actual decisions. Similarly, there is no official method in Thermaikos by which complaints, questions, and low performance might fuel initiatives for the development of new services. The pathologist stresses, “If frequent complaints were presented, I guess that administration would adopt such procedures to improve the situation. Since there are no such reports, then no measures need to be taken.”

Equally, there is no mechanism for integrating the views of customers into the service planning process. The medical services manager of Thermaikos characteristically states, “The hospital is not at this level of organisation and operation.” Still, it is noticeable that there is a high degree of flexibility and customisation of services regarding the needs of patients. The head of the nursing service points out, “we try to tailor services to patient needs. We do not follow any particular procedure, but patients’ selves are manifested through the expression groups and they propose ways of upgrading provided services.” Similarly, the social worker of Castalia states, “There is respect for the individual, and services are tailored to patients’ personalities.” The respondents of Eleftheria hospital maintain that the hospital makes efforts to evaluate its services rather than customise them. There is no central policy to determine detailed rules for adjusting. However, as indicated by the medical and nursing service manager, “medical personnel is fairly autonomous in the management of everyday life and incidents.” Moreover, according to hospital manager, the hospital collaborates with the associated doctors, the patients and their families, aiming at identifying the unit’s limitations and weaknesses. The results point to either the improvements that need to be made or the adoption of successful and profitable operations observed at other mental health hospitals. It is important to note, however, that there is considerable disagreement among participants of Galini hospital as regards the customisation of services. The medical staff highlight the importance of customisation in mental healthcare services and mention that personalisation of services to patient needs takes place. A psychologist argues that customisation is needed, because there are many patients with different characteristics and requirements that need to
be addressed. In contrast, the manager of the hospital appears to be rigid, noting that once a service is designed and developed, it should be given to all patients, as developed for each treatment stage in the same way, as planned, without differentiation. “The design of a service incorporates the rules of medical science and therefore any adjustment should be carefully considered,” he adds.

6.5.2.3 Patient involvement in case hospitals’ innovative activities

It is noteworthy that nearly all participants take the view that the corporation should increase patient involvement in new service development and venturing activities. Participants argue that patients could become more active, participating in creative activities that would broaden their involvement in innovative actions. It appears that Castalia’s administration is open to new suggestions as regards patients’ employment, i.e. hours of creative work, occupational therapy, etc. The psychologist argues that the hospital could also promote alternative types of employment, such as part-time work outside the hospital, while the social worker reports that hospital could increase patients’ involvement by setting rewards or other incentives. The psychiatrist goes a step further, saying that the hospital should encourage patients to make their own proposals for innovation and improvement. Participants of Galini hospital have identified a number of methods of increasing customer involvement in the hospital’s innovative activity. For instance, the manager reports that greater involvement occurs when patients are informed about services’ additional benefits. Furthermore, both pathologist and psychologist suggest the development of additional involvement activities, encouraging patients with rewards. Similarly, the head of the nursing team recommends the development of new occupational therapy groups aiming at the socialisation of patients and their participation in the hospital’s functioning. The medical services director of Saint Irene proposes, “As a first step, we could establish a partnership with a specialised organisation, which shall contact patients who used our services, a few days following their departure. At that time, people would be exempt from positive or negative experiences and would share their views objectively. Thus, the hospital will have a comprehensive picture of its service quality.” The scientific director adds, “Practices and methods for customer involvement should be adopted to enhance quality and meet special requirements of patients and families.” The psychologist also notes, “The hospital expects from staff to suggest new actions, new
 investments, or new areas that need expansion. These proposals arise in consultation with physicians, patients, etc.” Additionally, the occupational therapist states, “in mental healthcare, patients may further participate in innovative activities through the treatment groups, where they express themselves and communicate their concerns and wishes.”

Similarly, the managing director of Thermaikos adds, “We have not managed yet to get to where we want.” The psychologist suggests a regular discussion with patients or the distribution of a questionnaire to those who are responsible for patients’ care (doctors, nurses, etc.), including questions about their nutrition, hygiene and service provision in general. The purpose of such action would be to gain useful information and ideas for new offerings. The social worker adds that such actions should be adopted to reduce passivity and turn patients towards the community. The head of the nursing service agrees, adding that, at times, irregular actions take place. Nevertheless, the head of the nursing service of Eleftheria holds a different opinion, stating, “I do not think there is a method of increasing customer involvement, because of the industry’s nature.”

The analysis so far indicates that the scientific personnel of hospitals communicate with patients and are aware of their needs and desires. For instance, patients communicate through expression and discussion groups in Castalia. Therefore, the psychiatrist’s suggestion above already applies and does not constitute a method for widening patient involvement. Additionally, the nursing and scientific staff encourage patients to participate in innovative activities, though they approach novel offerings with caution. It also comes forward that no appropriate tools are used for measuring patient satisfaction, but only informal discussions with practitioners are applied for service improvement. In particular, most of the respondents (i.e. medical services manager of Thermaikos, patient services and admissions manager of Castalia, head of the nursing service of Galini, medical services director and scientific director of Saint Irene, medical and nursing service manager, scientific director, and pathologist of Eleftheria, etc.) agreed that that no particular tools are required to measure customer satisfaction for service improvement, since there is direct, daily personal contact.

6.6 Summary of findings

A summary of the findings can been seen below in Table 6.3.
Table 6.3 Summary of findings: Hospital executives and medical staff

<table>
<thead>
<tr>
<th>Questions</th>
<th>INNOVATION: Activity, factors, and business culture</th>
<th>Hospital Executives</th>
<th>Medical Staff</th>
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<tr>
<td>1. What are the internal factors that predispose the organisation to seek access to innovation?</td>
<td>The basic internal factors that motivate the units to be innovative are the implementation of good practices that save labour hours, the cost of raw materials/supplies, and increased employee productivity. Similarly, the attitude of managerial and scientific staff towards innovation and the evolving needs of patients constitute those internal factors that motivate companies to be innovative. Likewise, the evolution of technology, the incentive for development and enhanced quality of the service offerings, the need to remain competitive and have additional revenue from different sources in a time of crisis are among the factors that motivate hospitals to be innovative. In contrast, extraneous factors such as legislation — the operational framework of private hospitals - and the conditions of the local economy are negative for innovation, as there are constraints regarding mental healthcare provision. The operating framework set by regulatory mechanisms in state laws, changes frequently in Greece. As regards the economic factors, businesses that operate in Greece had benefited from the good economic climate and from easy credit; people could spend more easily than today. Social factors benefit innovation but do not bring about a commensurate financial result.</td>
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<td>2. How and to what extent do external factors such as legislation, social and economic, condition or stimulate favourable attitudes towards innovation?</td>
<td>Thermaikos and Galini hospitals have not promoted initiatives that could deliver rapid growth, while it should follow different strategies prior to reaching crisis. On the other hand, services are reassessed in Castalia and Saint Irene and generally, positive actions are being promoted, improved, and developed.</td>
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<td>3. Are adequate tools and processes used to generate opportunities for product development?</td>
<td>Medical staff has tried to set up procedures that would improve services, but this effort is still in its infancy. Overall, no adequate tools and procedures are used to develop or improve services.</td>
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<td>4. Does the organisation do enough to create:</td>
<td>All case hospitals aim to establish a culture where continuous improvement would be considered as a model, with constant communication with staff, frequent references to potential benefits, and encouraging employees to suggest new ideas for diversifying its services and enhancing quality. Castalia’s goal is to cultivate a culture where continuous improvement is regarded as a rule. There is daily monitoring of services, while the administration is open to positive initiatives. The CEO of Galini stresses that the proper mind-set is established through regular meetings, immediacy of communication from the lowest to the highest level and continuous assessment.</td>
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<td>i. A culture where continuous improvement is regarded as a norm?</td>
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<td>ii. Incentives for staff to identify and act on opportunities for</td>
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<td>improvement?</td>
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<td>5. How adequately or appropriately are the requirements of customers taken into account in the organisation’s innovation strategy?</td>
<td>Many patients have difficulty in indicating their desires; therefore, Thermaikos attempts to communicate with their relatives. Customers’ requirements are taken into account in innovation strategy, enhancing the hospital’s intention to provide quality health services. For instance, customer requirements are taken into account in Castalia’s innovation strategy to the point where they can meet and be applied to other customers’ conditions. Similarly, Saint Irene is open to views and novel ideas from customers. It considers them as the main driving force even in strategic moves, such as creating a new unit or a new service. Likewise, the hospital manager of Eleftheria supports that the market requirement and the development of medical science are the factors that impel the acceptance and integration of innovation within healthcare industry firms.</td>
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<td>Question</td>
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<td>6. Do you believe that customers can contribute something extra to the</td>
<td>Both administrative and scientific staff agree that patients could contribute further to the process of service development. The manager of Castalia stresses that those patients who express their demands already participate in the process. Similarly, executives in both Saint Irene and Eleftheria argue that patients may contribute and should be involved in the process of developing new and improving current offerings. However, there is still room for improvement regarding their contribution to the development of new services. Few believe that not all patients are able to share their opinions, make suggestions, or discuss their needs.</td>
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<td>service innovation process?</td>
<td>Many support that patients may contribute significantly to this process. Perhaps it could be done, up to a point, especially for something additional or different. However, the low social level in Theraikos complicates patients’ integration into development programmes. However, there are few patients and relatives who are friendly, have good living standards and assist the hospital. These people can communicate their opinions, especially if aided by special programmes for expression. Additionally, no opportunity is given to patients to express their aspirations because no such culture has been developed by the hospital that will take an interest in their deeper needs.</td>
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<td>7. What do you think is the role of the top executives/medical staff in</td>
<td>Staff play a determining role as they promote and reassess innovative services. The role of managers in the innovation process of a hospital is critical, as they are aware of the unit and area’s needs. Every manager is responsible for promoting solutions and bringing forward ideas for innovation. The role of top executives is the most important in promoting the internal innovation process. There are those who push for a decision to be taken, for an innovative activity, or for an innovative investment to be made. If executives do not give support to the suggestions of physicians and patients, then no proposal will proceed to the next stage. Top executives and scientific personnel, design and foster innovation, mentioning that their role is critical, as these are those who develop ideas and determine the method of implementation. Likewise, the administration team in Castalia appears not to penalise unsuccessful attempts, while assessment is intended to enhance the learning process. Therefore, it emerges that the case hospitals treat failure with clemency in an attempt to be innovative. The aim is to gain knowledge from such experiences, to improve the hospital’s operation and procedures.</td>
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<td>promoting the internal innovation process?</td>
<td>Respondents believe that the workforce is the driving force behind any attempt to innovate. Staff should keep up-to-date and adopt innovations to maximise their efficiency. Everyone who utilises their own knowledge seeks to improve and to promote new ideas to enhance the operation of the clinic. Consequently, efforts are assessed and new ways of improvement are sought, and failure is the beginning of all subsequent efforts to improve and progress. However, there is room for improvement regarding the participation of the scientific staff in fostering innovation. The role of physicians should be more decisive and the administration should develop a more fruitful cooperation with them. For instance, it appears that the voice of medical staff in Theraikos is unheard; there is scepticism from a part of the administrative staff, some of whom prefer to support the existing order.</td>
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<td>8. Do you believe that the stimulus of growth could help you become</td>
<td>Growth is defined as the main business objective of the case hospitals. Therefore, patients’ satisfaction, through the development of new services, is the hospitals’ strategic plan. The stimulus of growth significantly helps the hospitals’ innovative activity, developing new services and approaching new markets, resulting in new groups of patients, and economic return.</td>
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<td>more innovative, developing new services and approaching new markets</td>
<td>Better organisation and enhanced structures are required for the hospitals to proceed to the development of new services. The direct and continuous communication between administration, employees, administration, and patients builds the tenacity and dedication needed to achieve the desired result. For instance, Castalia could save resources, labour hours, and materials for the development of innovative services if it adopted better</td>
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<td>and why?</td>
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organisational and functioning systems. However, the views of participants are ambiguous. Some defend the organisation and the structure of the firm in implementing innovative actions, while others claim that there is room for improvement

### NEW SERVICE DEVELOPMENT: Process, service improvement and evolution, and coordination

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<th>Hospital Executives</th>
<th>Medical Staff</th>
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<td>10. Did the organisation introduce any new or significantly improved service in mental health sector?</td>
<td>Thermaikos hospital has not introduced any new or improved service in the mental healthcare market in the last two years. The problems of the past and the current financial crisis do not leave room for growth. However, Castalia hospital has attempted to upgrade and enrich its services to be creative and competitive. Contemporary facilities have also been founded for the laboratory tests to take place on-site for immediate handling of patients’ pathological problems, for activity groups for patients, and for the provision of intensive care services for occupational therapies. Galini has introduced three new groups of services within the previous year. One new set of services is associated with activity groups. Likewise, both Saint Irene and Eleftheria have not introduced any new services to the industry. The aim is to develop the current establishments in both infrastructure and in the manner of providing services.</td>
<td>Service quality has been markedly improved; contributing to better health for patients, while there is constant progression. The number of psychologists and occupational therapists on duty has been increased. Galini has adopted experiential psychotherapies, a new service offered by qualified staff, which involves outpatients who follow some form of treatment, but need not be hospitalised. There has also been developed a psychosocial rehabilitation service, based on regular and customised clinical and psychosocial investigation of a patient’s capabilities and needs.</td>
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<td>11. How many new services did you introduce last year?</td>
<td>A plan has been carried out in Thermaikos over the last two years to improve services, upgrading hospital’s building infrastructure and recruiting qualified and experienced personnel. Overall, services are routinely monitored in terms of efficiency and satisfaction, and then improved. There are times where small changes lead to complete transformation of a service. Overall, great importance is given by the case hospitals in establishing new open structures that will reintegrate patients into society.</td>
<td>Services have changed significantly over the past two years. Integration of new specialties has resulted in improved health for those patients who underwent psychotherapies and developed their skills. Likewise, attempts to improve service quality for both patients and employees have had effects. For instance, Thermaikos hospital adopted programmes and initiatives to improve its treatment methods over recent years. Likewise, new programmes for some patient groups have been added in Galini, such as cognitive programmes for those with dementia; excursions; autonomy groups; etc.</td>
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<td>12. How and to what extent has your service products changed during the past 2 years?</td>
<td>Overall, there is a guiding plan that covers services expansion and development of the case hospitals. Every component of this plan is designed considering both internal and external factors (social, economic, legal etc.). For instance, Castalia hospital has a plan for the growth, despite the fact that it is still at the stage of idea generation and organisation. As for Thermaikos, there is no short-term plan for the expansion of operations or the development of services. The hospital tries to address some internal issues and survive, overcoming the crisis.</td>
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<td>13. Does the organisation have a plan for the extension and evolution of its services?</td>
<td>As regards medium-term planning, there are only thoughts and ideas, which mainly originate from existing customers and the hospital’s vision. For instance, ideas for new services derive from the market, discussions with customers, and staff initiatives. The ideas also arise from developments in science; existing and potential patients; medical staff; information on what happens in other structures, and any changes in the legal context.</td>
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<td>14. Where did the concept of developing new services come from? (existing customers, new customers, market research, always part of the plan?)</td>
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15. **How would you evaluate the coordination among people and departments throughout the new service development process?**

Coordination among people and departments throughout the process of developing new services is advantageous in Castalia, Saint Irene, and Eleftheria. There is an exchange of views between heads of departments on a weekly basis; discussions are followed up in monthly executive meetings to define further actions. However, in Thermaikos and Galini hospitals, there were deficiencies in the organisation and implementation of new projects; therefore, there is room for improvement.

16. **Will you please describe the venturing and entrepreneurial activity in the organisation?**

The entrepreneurial models of Castalia and Saint Irene appear to be based on the demand-led provision concept. The hospitals explore opportunities that emerge from the requests of customers or doctors. Likewise, the entrepreneurial models of Galini and Eleftheria focus on the development of services and business units that will cover the needs of the maximum number of patients. In contrast, Thermaikos’ manager appears not to have sufficient information about the hospital’s entrepreneurial model and new business development initiatives. He argues though that there are opportunities for growth.

17. **What are the hospital’s venturing objectives?**

The entrepreneurial goals of Castalia are to expand its services into other sectors of healthcare, i.e. rehabilitation sector, and also develop a small network of primary mental healthcare settings that will cover the needs of the wider region. Similarly, the business development goals of Saint Irene define the geographical spread of services, achieving maximum population coverage and development across all sectors of mental healthcare. Eleftheria focuses on primary care, aiming to develop centres so that mental patients can be treated from the beginning of the illness until their reintegration into society. Likewise, Galini considers the expansion of its business to cover areas in mental healthcare that are still unexploited, by developing a network of small units in the region that will provide primary healthcare services for mental patients. In contrast, Thermaikos’ manager answered negatively to the questions that regard the hospital’s venturing objectives, arguing that the current economic conditions do not allow implementation of growth plans.

18. **How are entrepreneurial opportunities identified, evaluated and selected by the organisation?**

There are several ways to identify entrepreneurial opportunities, such as by eavesdropping the market or by involving stakeholders in the development process. Entrepreneurial opportunities are identified by market research and evaluated by hospitals’ executives, and doctors. They decide which opportunities worth exploring according to the needs, the competition, and the current economic situation. Following this, industrial reports show which sectors will continue growing in the near future.

19. **How does the organisation encourage and support entrepreneurial activity? How does it recognise and reward innovative efforts?**

Thermaikos provides the necessary time to employees to share their views and suggestions concerning hospital’s operations, but does not implement any processes that would reward such efforts. In the case of Castalia, prior to making an investment, a scientific evaluation of innovation is conducted to show how and to what extent this would provide a solution to a therapeutic or a diagnostic problem. Secondly, the number of possible incidents that can be served by this innovation is being estimated. Thereafter, a business plan is developed to show whether this initiative is viable in reference to the prices and the cost of the investment. In addition, the management team gives moral rewards to innovative employees. Galini allows stakeholders to take initiatives for growth. In some
cases, they allow associate doctors to lead and invest in an effort, providing the necessary administrative and financial support. Saint Irene encourages its partners-investors to provide new ideas for investment to develop the operations of the company and gain a larger market share. Likewise, Eleftheria recognises innovative efforts by rewarding employees for their ideas and the additional work that they had to carry out.

**CUSTOMER ORIENTATION: Market assessment, customer relationships and involvement, service customisation, customer satisfaction**

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<th>Question</th>
<th>Hospital Executives</th>
<th>Medical Staff</th>
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<td>20. What preliminary market assessments occurred before any investment was undertaken? (market research, market segmentation)</td>
<td>Market research is a daily, open process. Estimates occurring prior to any investment are from market research. For example, the manager of Galini hospital indicates that for an investment plan, they consider demographic conditions, look for appropriate scientific personnel, and evaluate the ripeness of the market. Additionally, Saint Irene seeks to learn from its competition and associate doctors, who usually express their requirements prior to the implementation of an investment, as they are well aware of local market needs.</td>
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<td>21. Is there a clear idea of the type of information to be obtained through market assessment?</td>
<td>The first element to explore is whether there is sufficient number of customers-patients as well as the economic background of the area in question. Information is often required about local needs, competition, and infrastructure for business development initiatives. Overall, there is a clear idea about the kind of information that should be obtained through market assessment (i.e. number of patients in the local community; need for new services; potential cost of investment; financial return; etc.).</td>
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<td>22. How much time and effort is spent in conducting interdepartmental meetings to discuss market trends and developments?</td>
<td>Interdepartmental meetings are conducted in both Saint Irene and Eleftheria to review developments and market trends. Firstly, the problems of the units are discussed as well as the local competition. Thereafter, regular meetings are organised with executives and managers, discussing the progress of all units, industry developments and the firm’s positioning, suggestions for development/improvement, etc. Similarly, regular interdepartmental meetings are conducted in Castalia to discuss developments and trends. Likewise, the estimated number of potential patients and their needs, and their capacity to pay for these services, constitute some of the information that needs to be obtained through market assessment, so departmental meetings between management and scientific staff in Galini discuss developments and market trends. However, no departmental meetings are held in Thermaikos to discuss market trends, but only informal discussions among hospital executives with reference to developments in the mental health sector.</td>
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<td>23. What type of relationship does the organisation have with its customers?</td>
<td>The relationship between the hospitals and their customers is based on sound service provision, as they appear to choose these hospital units to tackle their problem if they relapse. Patients and relatives feel quite satisfied by the quality of services. The relationship between the hospitals and their customers is interactive. This creates a trusting relationship over the years. For instance, the everyday engagement with patients and their relatives facilitates the provision of the services that every customer needs. Similarly, administrative and medical staff promote trust as a key ingredient in the relationship with patients at Galini hospital. Staff strive to learn about their needs and preferences. Good cooperation and maintenance of the relationship comes about through high quality services and patient satisfaction.</td>
<td>The relationship with patients is optimal and maintained through daily contact. Continuous communication is carried out through doctors’ daily visits to patients’ wards, regular sessions with psychologists and psychiatrists and frequent updating of relatives. For instance, Thermaikos hospital tends to operate near capacity. This proves a good relationship with patients. Likewise, medical staff try to establish good relationships and communication with relatives in Galini hospital. The relationship with families is tending to improve. Similarly, Saint Irene maintains tight and daily contacts with physicians, giving incentives for cooperation, and organising relevant events. Moreover, the relationship with patients begins and finishes inside Eleftheria hospital and is maintained by offering superior quality. In addition, deinstitutionalisation is moving very slowly in Greece, so some...</td>
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24. Is there an adequate process to track and respond to customer queries and complaints? If so, does management get an up to date status of complaints?

| Patients have spent their entire lives in the hospital. In those cases, an interpersonal and even a kind of "family" relationship have been developed. |
| There is no formalised process for recording customer requirements, by which complaints, questions, and low performance might fuel initiatives for the development of new services. However, there are informal processes through the cooperation of managers, so that patients' complaints may fuel initiatives that meet their needs. Complaints are expressed verbally to medical staff. Patients informally express their opinions and make comments to psychologists and the administration of the hospitals is then informed in all cases. The hospital managers are responsible for providing solutions in cases where major concerns are recorded. |
| Dialogue and consultation among patients and doctors are used as tools to solve the problem. In most cases, it seems that the administration of the hospital is being updated. Likewise, associate physicians who refer patients to the hospitals reflect on the services provided and then the companies receive feedback, availing themselves of an excellent relationship with these physicians. Furthermore, the scientific director of Thermaikos noted that the administration of the hospital would adopt procedures to improve the situation if frequent complaints were presented. Since there are no such reports, then no measures need to be taken. |

25. Is there a robust mechanism to integrate the views of customers into the service planning process?

| There are no formal tools, procedures or mechanisms to incorporate the views of customers into the process of designing new services. Only informal meetings among departments are conducted to discuss such issues. |
| There is space for customisation and judgement regarding customers' requirements. In some cases, high degree of flexibility regarding the needs of patients, trying to tailor services to patients' needs. For instance, Saint Irene makes efforts to evaluate its services rather than customise them. However, the CEO of Galini believes that once a service is designed and developed, it should be given to all patients, as developed for each treatment stage in the same way, as planned, without differentiation. |
| The medical staff highlight the importance of customisation in mental healthcare services and mention that personalisation of services to patient needs takes place. There is respect for the individual and services are tailored to patients' personalities. |

26. How much room is there for customisation and judgement on the part of service provider?

| Overall, respondents agreed that the hospitals should increase patient involvement in new service development and venturing activities. Participants have identified a number of methods of increasing customer involvement in the hospitals' innovative activity. Patients could become more active, participating in creative activities that would broaden their involvement in innovative actions. Hospitals' management teams are open to new suggestions as regards patients' employment, i.e. hours of creative work, occupational therapy, etc. For instance, the manager of Galini reports that greater involvement occurs when patients are informed about services' additional benefits. |
| Medical staff suggest the development of additional involvement activities, encouraging patients with rewards. For instance, a regular discussion with patients or the distribution of a questionnaire to those who are responsible for patients’ care would be useful. Such actions should be adopted to reduce passivity and turn patients towards the community. In addition, hospitals could promote alternative types of employment, such as part-time work outside the hospital, while it could also increase patients’ involvement by setting rewards or other incentives. The hospitals could encourage patients to make their own proposals for innovation and improvement. |
28. Are there measures of customer satisfaction that you use to improve your services?

| No appropriate tools are used for measuring patient satisfaction, but only informal discussions with practitioners. However, the executives of Galini support that no particular tools are required to measure customer satisfaction for service improvement, since there is direct, daily personal contact. Overall, customer participation in new service development activities is poor, even though the case hospitals recognise its importance. |

6.7 Conclusion

This chapter discusses and shows that the stimulus of growth is the key factor for the case hospitals’ innovativeness, whereas the current financial crisis is the major obstacle for a business in expanding its operations. For instance, it becomes clear that innovation is used by Castalia hospital to save labour hours, decrease the cost of raw materials/supplies, and increase personnel’s productivity. Customer satisfaction and service quality have not been mentioned, though, as essentials for innovation. Likewise, it appears that competition and the evolution of technology enhance innovative activity. In contrast, legislation and current economic condition appear as obstacles for firms seeking innovation, while the social factors, which could boost innovation activity, do not match up to an equivalent financial outcome, according to the manager of Thermaikos hospital.

Moreover, responses point out that administrations try to establish a culture where constant improvement would be considered as a norm, but generally, no sufficient tools and processes are employed to develop new offerings. For instance, Saint Irene makes efforts to establish a culture in which people would take initiatives for improvement, solve problems, and develop ideas that would assist the company to reach its goals. This is achieved by offering a number of stimuli, such as moral, financial, and institutional rewards. Yet, although efforts are being made, neither is an organised process followed for new service development, nor does a culture exist that might promote innovation and improvement. In fact, executives and medical personnel of Castalia gave dissimilar answers regarding motivations given to staff to generate new ideas and detect deficiencies. Some responded that incentives are offered, while others stressed the opposite, considering themselves as low-motivated employees. Equally, a few middle-management executives of Saint Irene support that no such motivational actions ensue from good practice, that there is no adequate organisation within the company, despite its growth, and at this difficult time, no proper actions are being taken to ensure the continuing viability of the firm. They claim that even though there is a planning team, which investigates and suggests new developments, it does not undertake a formal
procedure to refine and expand the concept of the new outcome; determine its profitability and feasibility; establish standards for its performance; assess the market prior to commercialisation and introduce it to the public using the tools of the marketing mix. This might explain the reasons of not developing new service offerings the last two years. Similarly, Thermaikos seems not to encourage employees in any way to identify and act on opportunities for improvement. In this case, it appears not to be clear the role of medical staff in the development of patient oriented services (RQ2 and RQ3).

Additionally, most of the administrative and scientific staff who participated in the study concur that service users may play a key role in the service development process. For instance, customer requirements are considered in Castalia’s innovation strategy, and customer needs are taken into account in Galini’s innovation strategy, but it is seen that patients do not contribute further to new service development. Likewise, some members of Thermaikos’ staff strongly believe that service users should contribute to the development of new offerings, resulting in a more patient-oriented process. Although the hospital manager reported that most patients are not able to express themselves, and the scientific director indicated that hospital’s culture does not allow customers to express their deeper needs, it does emerge that the administration attempts to consider customers’ views to facilitate quality health services. On the contrary, it appears that Saint Irene and Eleftheria do not take into full account the requirements of customers in development activities entirely, as many interviewees believe that patients may only contribute to the everyday services they receive apart from medical ones. According to the respondents, new ideas derive mainly from hospitals’ managers and associate physicians and less from patients and families. The latter also shows the level of contribution of customers. It also emerges that patients’ suggestions are a useful tool for service improvement, but doctors have the last word on the new development. The latter provides an insight regarding the first research question (RQ1). It comes forward that customers do not play a key role in the development of health services.

Furthermore, many agree that the role of executives and medical staff is critical in advancing innovative activity. For example, Galini’s employees recognise their own importance in adopting and promoting innovation, as they generate ideas, design new outcomes, and monitor the development process. Likewise, there is an agreement in both
Saint Irene and Eleftheria that the role of top executives and scientists is critical in promoting the internal innovation process. For instance, Saint Irene aims to develop close relationships with doctors, as they are able to provide assistance and knowledge regarding customer requirements and gaps in the market place. This shows that medical staff plays a key role in the development of patient oriented services. However, the difference between executives’ and other staff responses becomes apparent in some cases, as regards the role of medical personnel in promoting the innovation process. Although every participant recognises their importance, it is remarkable that their views are often not taken into account in Thermaikos hospital. Similarly, the middle-management staff of Saint Irene would expect more from company’s administration regarding the level of cooperation. Those findings illustrate the importance of both customers and medical staff in new service development, providing insights regarding the role of patients in the process as well as the perception of medical staff in patient involvement. The findings also show that both customers and medical staff play a key role in service development, with doctors supporting the participation of patients in the process (RQ1, RQ2 and RQ3). It seems, however, to be a confusion between administration and medical staff of Thermaikos hospital about the role of customer in new service development (RQ1) as well as the role and willingness of medical staff in developing patient oriented services (RQ3).

Moreover, the hospitals appear generally not to sanction failure, but prefer to increase its awareness. Unsuccessful efforts are not treated with severity, but are seen as an opportunity to gain knowledge and to improve. For instance, the administration of Galini is not harsh on failures, choosing rather to gain knowledge and improvement from such incidents. Likewise, there is a relative ease and freedom of movement in innovative activities in Eleftheria hospital. This explains how the administration team of the hospital recognises and assesses failure and gains knowledge. However, there is no such self-determination in undertaking innovative initiatives. The top executives of Castalia hospital believe that the stimulus of growth along with a proper organisation could advance its operations, offering significant financial results. It is seen that Castalia has a strategy for growth, which originates from the market, customers, and staff. The hospital is also developing a plan to enhance its service offerings to become competitive and user-friendly. This is implemented by modernising its facilities, employing additional scientists, and developing new activities for
service users. Those efforts have significant outcomes as regards patients’ health condition. In contrast, the findings indicate that Thermaikos hospital has not developed a new service offering within the last two years, but has rather focused on improving infrastructure and basic service quality (i.e. administration of drugs, hygiene, food, etc.). Similarly, the CEO of Galini seems to ignore the importance of organisation and structure in the implementation of innovative actions. He takes the view that good communication among staff and customers is all it takes for a firm to be successful.

What is more, it emerges that coordination among people and departments during the service development process is constructive in Castalia. This cooperation is characterised by enthusiasm for exchange and self-motivation, even though there is a need to exploit new services to a greater extent. Furthermore, it is clear that some market assessment takes place, gathering information about current demand for mental health services and customer requirements for new outcomes; no regular meetings, however, are conducted to recognise market trends and industry developments. It is noteworthy to underline that although the administration of Galini disregards organisation and equates it with bureaucracy, they note that the main entrepreneurial objective of the hospital is further to expand its services and to fulfil unmet needs of customers. Therefore, data is collected with regard to medical science, current and potential customers, the competition, and the legal context, to build a strategic plan. It is also clear that innovative initiatives lead to new offerings, such as new activity groups, cognitive programmes for those with dementia, experiential psychotherapies, and others. Accommodation services have also been upgraded.

In contrast, it emerges that there is a problematic issue with respect to the level of cooperation between employees at Galini hospital, many respondents noting that there is room for improvement and people should work together to increase success. Similarly, respondents from Saint Irene disagree with reference to the firm’s organisation and structure. Some believe that the hospital’s organisation and structure enrich innovative actions, while others blame them as a hindrance to the development effort. One concludes though that some actions have taken place to improve organisation and cooperation, but there is reasonable concern regarding communication and collaboration between the scientific personnel and the management team, which emerge as challenging. In addition, it comes
forward that there is no strategic plan for the expansion of services, nor is market assessment performed by Thermaikos hospital. It, however, maintains tight relationships with service users, while lacking, nonetheless, organised procedures and appropriate tools for keeping details about customer requirements and complaints. The above description shows that some of the examined hospitals utilise innovation to expand and improve their offerings, but no plans are developed to engage in corporate venturing activities. For instance, it comes forward that Thermaikos does not utilise innovation to expand its services, showing also that it does not engage in corporate venturing activities. Similarly, the above findings show that there is no interest from Galini to utilise innovation to engage in corporate venturing activities (RQ4).

Another point is that staff engage in continuous communication with patients to identify and fulfil their needs. This results in a relationship of trust among participants, which is maintained by comprehending patients and reinforcing the possibility they might contribute to services. For example, Eleftheria’s intention is to keep them satisfied, providing high quality services at short order. Thus, it has adopted a number of ways to allow patients to express themselves. In contrast, administrative staff of Thermaikos do not seem to consider patients’ needs when planning to provide high-quality services, adopting new methods of treatment, developing new structures or implementing a patient-focused programme. Indeed, the hospital manager appears to be somewhat weak, avoiding taking initiatives, but waiting for directions from his superiors. Additionally, it is evident that Castalia hospital does not use any process to examine customers’ issues and criticisms and integrate them into new service development, nor is there a mechanism through which low performance and complaints could stimulate service development initiatives. Likewise, Galini hospital aims to build relationships with both patients and relatives, however, it is clear that neither adequate procedures to observe customer complaints, nor formal methods that guide the development process, are employed. This means that unofficial methods and processes are applied to both customer responses and new service development.

It is worth mentioning that customers’ views are not taken into consideration in service development processes of Saint Irene and Eleftheria. The responses show that there is a poor system of integrating their thoughts and requirements into innovative activities, as no formal method exists by which complaints, queries and poor performance might stimulate service
development initiatives, nor has a forceful mechanism been created to integrate the views of customers into the service planning process. Therefore, there is much room for improvement, as no proper tools are used to appraise customer fulfilment. In addition, an incongruity has come to light regarding customisation of services at Galini hospital. Although the medical personnel underline the importance of flexibility, since every customer has particular needs and desires, the manager persists in stating that services should be offered as designed, without adaptation to patient requirements. Likewise, Thermaikos hospital needs to be reorganised to operate in a different context, following medical developments in treatment methods, customer service culture, opening up new structures and offering services to a wider range of mental patients, and actively integrating scientific personnel and patients into new service development processes.

On the other hand, many participants argued that hospitals should augment patient participation in new service development and venturing activities. Especially in mental healthcare, service users should be actively involved in their treatment decisions, guiding experts towards the development of high-quality customised offerings. For instance, the scientific personnel of Castalia already provides a number of approaches / activities through which service users could increase their involvement in the hospital’s innovative activity, such as hours of creative work, part-time employment, scientific discussion groups, and so on. Similarly, the medical staff of Galini propose numerous ideas for further customer involvement: development of relevant activities; occupational therapy groups enhancing patients’ socialisation; participation in hospital work; etc. The above present a contrast between the importance of patients in service development and the tools and processes that are used to achieve this. It is noteworthy that even though the administration considers customers as an important stakeholder, it has not adopted mechanisms to integrate them in new service development. Therefore, it is not clear in this case how mental service users could be involved in the service development process. Overall, the findings provide alternatives of mental service users contribution in the service development process and show that medical staff is positive to patients’ participation in such processes (RQ2 and RQ3).

The next chapter discusses the findings from the five case hospitals. The innovation activity of each hospital is summarised, the development process of health services is
reviewed as well as the role of customers and the involvement of patients in new service development is examined.
 CHAPTER 7
DISCUSSION OF THE FINDINGS

This chapter summarises the main findings of the two phases of the primary research. Following the conceptual research framework, the innovation activities and venturing objectives of the case mental hospitals are reviewed. Then the level of customer-orientation within the hospitals is examined. Finally, Figure 7.1 illustrates the major parameters that affect the organisations’ innovation and entrepreneurial activities.

7.1 Outline of findings

The most interesting cases of innovation in healthcare are found in emerging markets. This mainly because necessity creates the need for innovation (Ireland and Webb, 2007). In the absence of adequate healthcare, care providers are forced to improvise and innovate (Krusen, 2012; Burns, 2012). In this study, there is an analysis of data across all of the cases to identify similarities and differences in the degree of application of innovation in the mental healthcare sector in Northern Greece and its impact on different hospitals. By identifying similarities and differences, this research aims to provide new useful insights into several issues concerning the use of innovative services in the healthcare sector in Greece and offer generalizations based on the results of the selected case studies. One of the arguments of Chapter 6 is that to be able to reach useful and valid results the use of a theoretical framework is required. The theoretical framework is being used as a template for comparing and generalizing the empirical results of the different case studies. Studying multiple cases makes it very likely to create a logical sequence of evidence (Yin, 2014). Clearly, the cross-case analysis is used in an attempt to seek a chain of valid evidence and explain the relationships created and examined based on the framework (Shannon, 2014). To answer more effectively the research questions in this study, the results of the cross-case comparison are discussed and examined by comparing data from the different case studies.

Substantial initiatives towards user involvement in decision-making and service planning seem to stumble upon the structural rigidity of the case hospitals and the lack of formal coordination of different sections and services. Mockford et al. (2012), and Peck et al.
(2002) suggest that user involvement is encouraged at the level of consultation, however, the systemic integration of involvement activities into entrepreneurial planning is somewhat missing according to research studies conducted in the UK (Varady et al., 2015; Wallcraft and Bryant, 2003). The interviewees demonstrated that there is still a culture of segregation of mental health patients, which hinders efforts towards enhancing existing roles, activities and relationships. It was claimed that hospital staff should be more open to changing their roles and adjusting their behaviour to accommodate patient involvement. In theory, the argument continues, patient involvement is an appealing buzzword as it takes a high degree of commitment and courage from the part of medical and nurse staff to embrace change. Clearly, what is missing is an informed strategy, which would underpin such processes. Especially in the mental health sector, continuity of care across various services and sectors to meet mental patients’ complex psychological, emotional, and social needs is a broad consensus (Glisson et al., 2012). Not only is coordinated funding and organisation a vital step, but intersectoral collaboration with wider social agents is requited to cater for the patients’ diverse needs (Anderson et al., 2012). Such an approach, as we have seen in the literature review (chapter 2), presupposes the utilisation of integration mechanisms, knowledge sharing and transfer, a high degree of flexibility of business models, and overall a positive attitude towards technology innovation (Carayannis et al., 2014). Budgeting, planning, and management opportunities should inform commitment to user involvement models. The lack of understanding among senior staff members about the degree of collaboration between departments and units is an undeniably negative factor in the development of patient involvement models.

As the CEO of Saint Irene pointed out, the lack of entrepreneurial culture that would be supportive of user involvement and other formal mechanisms of service integration is the fundamental reason why innovation is hindered. The CEO of Galini clearly does not believe in the ‘representativeness’ of individual patients in key aspects of formal planning procedures. Therefore, any form or degree of patient involvement is not a determinant in promoting or assessing best practice. Millar et al. (2015) underline that professionals often resist giving credit to mental health voices and so would undermine serious attempts for greater user involvement. One way to explain this is as a kind of professional resistance to knowledge and power transferring to patients. Informal procedures, where patients are given the chance to
express concerns or wishes, may be well supported by the managers and physicians, but without thoroughly planned and developed measurement and assessment methods, their effect or contributions are in fact questionable. Indeed, there are well-reported discrepancies between expressed support and actual practice in mental healthcare settings (Peterson et al., 2014; Campbell, 2001). Service development is only feasible when accompanied with proper evidence base.

There seems to be a gap then between policy rhetoric and actual practice as this is demonstrated in the discrepancy in the opinions expressed about the level and efficacy of innovation programmes in the case hospitals. The chairman of Saint Irene hospital seems to support the idea that meaningful investment programmes in innovation activities are put in place and communication and coordination are functional elements in the organisational structure of the company. Surprisingly, the business development manager of Thermaikos and the hospital manager of Galini do not share these views. The hospital manager of Eleftheria has stated, “My goal is to provide an environment as safe as possible, ensure that patients are supported, fully informed of their diagnosis and treatment.” The quality and medical services manager of Castalia added, “We are trying to collaborate with medical personnel and provide the best provision services we can.” Decision-making structures within the case organisations need to change to create a scaffolding for what has been described as a ladder of power sharing (Kemshall, 2000; Barnes and Bowl, 2001). Increased user involvement would ultimately change the balance of power in the organisation (Tambuyzer et al., 2014; Foss et al., 2011), with professionals, practitioners, and stakeholders being ready to step up to the challenge. The existing power structure in the case hospitals is evidently hierarchical with top executives and senior medical staff being in charge of making decisions on service provisions and innovation programmes. The ambivalence of medical professionals about training, recruiting and employing of service users clearly reflects their resistance to seeing patients as valuable and equal partners in decision-making planning and development. Patients’ involvement in care services would be a problem stemming from confusion over staff-service user role boundaries. Hospital staff would be uncertain as to how to incorporate patients’ views and feelings and most of all how to encourage such responses. An SDO-funded study (Gillard et al., 2010) looked at contrasting case studies on self-care initiatives in mental health trusts, demonstrated a positive relation between increased patient confidence and
empowerment, and reduced levels of emergency admissions. Mental health patients need guidance and training to be able to discern the individual and collective benefits of their involvement in the services they receive, not to mention ongoing support and understanding (Millar et al., 2015; Van der Ham et al., 2014). In one study conducted by the Sainsbury Centre for Mental Health (2010), interviewed patients were unsure what to expect from involvement form the outset, but were generally keen to take up initiatives. The same study demonstrated that a successful patient integration model requires clarity of information and proper communication of important issues so that patients can reach informed decisions. The study also revealed a degree of resistance on the part of the professional staff, which significantly hindered the patients’ meaningful participation in meetings, review processes and other formal procedures.

The view held by the CEO of Galini and the managing director of Thermaikos that mental health patients cannot productively participate in the innovative transformation of the services provided to them consists of a key point in the policy context of those hospitals organisation and coordination of their mental health services. Their discursive construction of the ‘mental health patient’ positions them as passive recipients to be cared for rather than active partners in policymaking. At the level of service planning and development, the role they could play in radical change is overlooked. This position jeopardises giving patients a stronger voice in relation to mental health planning with such efforts remaining isolated and fragmented (Storm and Edwards, 2013). The overall effect of such a user involvement discourse tends to pathologise, individualise, and homogenise the experiences of users, constructing a disempowered position within the policy context of mental healthcare service. The senior medical staff and hospital managers stated that there are leaflets that service users can fill in, which in fact most of the times neglect to do so. Implicit in this view is the expectation that users largely lack interest or motivation to participate in such processes of user involvement or that their role should adhere more to the “consultation” model of participation. This view ignores the fact that the lack of opportunities for guided training and support to service users deprives them of the capability for informed choices they could otherwise exercise (Mockford et al., 2012). It is a denial of their potential to participate as active and meaningful partners. What is more, in statements such as “patients are invited to review the quality of their services upon completion of their treatment” implies a limited role
bestowed on them, which is more about evaluating existing policies rather than being encouraged to participate in planning and development. The view that appropriate decisions about planning are made by those appointed to do so implies a hierarchical structuring within the organisation and thus leaves little space for user involvement, if any. When medical and management staff do express a positive view about user involvement, their discursive construction of such a model reveals confusion and uncertainty (Rise et al., 2013). They do express a positive assumption that “patients should take an active role in the management of their care,” but do not seem confident in suggesting specific notions of user involvement or clear implementation concepts.

Training programmes are important in helping mental health professional staff develop the capabilities necessary in adopting in their everyday practice based on the patient empowerment theory. It is clear in the present study that there is a mixture of responses from mental healthcare staff regarding service-user involvement in all areas of mental health. A number of them indicated a reluctance in accepting patients’ contributions as a necessary part for effective practice. It becomes evident that a vital part of training should be about addressing the cultural and social factors within organisation structures in mental health that obscure the efforts towards user involvement. The distribution of power within organisational structures needs to change to acknowledge patient empowerment in decision-making processes. It is evident that the approach of the case organisations to organisational performance relies on the practical understanding of market operations, start-up financing, ICT-based integration services, skills-based training, and careful employee selection. The organisations, as many others in the mental health sector in Europe, present an authoritative model of business development. This means high ratios of psychotherapy staff and business experts. Its internal structure is geared towards offering few opportunities for user service involvement. At the same time, there is an effort observed to coordinate services across various departments and units to deliver improved care outcomes. The case hospitals are aiming at two different approaches to innovation: 1) through product innovation which refers to the introduction of new types of goods and services for the external market and 2) through process innovation, which refers to the enhancement of internal production processes for goods, and services. It seems that they have so far invested heavily in product innovation,
which has generated incremental revenues. Process innovation is still underdeveloped. It could however, improve the internal capabilities of the organisation.

Patient involvement in evaluation of services still follows a silo mentality and is routinely pursued through the dissemination of leaflets and questionnaires to patients. It is a fact that when healthcare providers do not promote a systematic approach to include users’ insights in decision making mechanisms, then the sharing of information and the delivery of care can become challenging (Storm and Edwards, 2013). This attitude may be explained on the grounds of medical professionals’ and business executives’ scepticism about mental health users’ adeptness to participate in such processes (Ennis and Wykes, 2013). Overall, the case hospitals have created opportunities for the so-called disruptive innovations. They entered new markets, delivered added value to stakeholders through the provision of new, improved services and have created new players in the market. They are looking for opportunities to further their disruptive innovation efforts by allocating money to venture funds. Nonetheless, less focus has been given to innovations in networking and communications synergies. The opinions of experts (executives - research phase 1 - and medical personnel – research phase 2 – see chapter 5) and findings from the documentary research (see chapter 3) are taken into consideration to answer the four research questions: RQ1 - “Where, how and why should patients be involved in new service development?”, RQ2 - “How do medical personnel perceive patient involvement in new service development?”, RQ3 - “What is the role of medical personnel in patient-oriented service development?”, and RQ4 – “How and to what extent is corporate venturing developed by adopting service innovation initiatives?” Table 5.2 in chapter 5 presents the measurement items for the two research phases, including the subjects to be measured as well as the sources of those questions. Likewise, Tables 6.1, and 6.2 in chapter 6 show the objectives of every question that was used to interview the top executives and the medical staff of the case hospitals. Finally, the Table 6.3 in chapter 6 summarises the findings of top executives and medical personnel in the five case hospitals.

7.2 Service innovation activities in case hospitals

This section aims to summarise, compare, and contrast the answers of top executives of the case hospitals with those of the medical staff. It will set the background for RQ1 – “Where,
how and why should patients be involved in new service development?" It becomes clear that top executives of the case hospitals recognise the importance of both innovation activity and entrepreneurial development. They have also identified a number of factors that encourage the company to seek access to innovation: evolution of technology; attitude of managerial and scientific staff towards innovation; evolving needs of patients; the quality of the service offerings; the need to remain competitive and have additional revenue from different sources in a time of crisis. Those factors appear to have a strong positive effect on the company to seek business expansion and development (Heimonen, 2012). What is more, a hospital manager mentioned other aspects that promote innovative activity: implementation of good practices that save labour hours; cost of raw materials/supplies and increased productivity at work. This is supported by the study of Harris et al. (2013), which discusses the value of business improvement methods in innovation implementation. Such actions are likely to encourage innovation, emphasising on the effectiveness of managing the resources and of exploiting the power of technology (Mueller et al., 2013). In contrast, other factors, such as legislation, finance and social factors appear to hinder firms that operate in the Greek healthcare industry. In particular, regulations change too often, the business environment is fluid, the financial crisis deters innovation, and meeting social factors does not offer commensurate economic outcomes. The above characteristics of the examined industry and region’s ecosystem hinder initiatives that aim to boost business development, described as systemic innovation problems in Wieczorek and Hekkert’s (2012) study.

The administrations of the case hospitals state that several tools are used to identify the needs of customers and assess the healthcare market, (i.e. management information systems and questionnaires). However, those tools have not been adopted by all psychiatric hospitals, as managers and medical personnel recognised that they do not use appropriate tools that help the development of new offerings. The study of Mueller et al. (2013) emphasises the importance of adoption of technological tools, such as customer journey mapping, benefits realisation planning, modelling and simulation to recognise and integrate customers’ needs in service development processes. Even though no official processes for the development of new services are adopted, both executives and hospital managers stressed that a basic and informal process of four steps is followed (i.e. idea generation; service design; service development, and final service evaluation). Then, disagreement emerges between
administration and scientific personnel as regards incentives for development. Top executives and hospital directors argued that the hospitals attempt to develop a business culture where everyone could undertake initiatives to enhance service quality, meet customer requirements, decrease operating costs, generate new ideas for expansion, promote service products, and develop beneficial relationships with the community. On the other hand, medical and nursing staff complained that no such actions take place and the firm is far off its targets. Respondents agreed, however, that the role of top executives and medical personnel is critical regarding the adoption of innovation and the reinforcement of the service development process. Still, there is scope for improvement, as many highlighted that there are gaps regarding staff participation in the decision-making process and their cooperation with administration. Nonetheless, it has been found that the case hospitals are not rigorous about efforts that fail, but prefer to gain knowledge from such events, to improve its assessment techniques and increase the chances of success for future attempts.

Additionally, an argument arises with reference to the hospitals’ organisation and structure. Some executives argue that they have built a system where innovation flourishes without constraints. Most respondents, however, believe that further actions should come about to upgrade organisations’ structure and attain better outcomes. In any case, participants argued that the stimulus of growth advances innovative activity and, for example, Saint Irene grows, aiming to expand its operations by developing novel services that fulfil customers’ growing needs. The latter is particularly important for the firm, as the administration underlined that customers, together with other stakeholders, guide the organisation’s innovation efforts. Therefore, Saint Irene engages customers’ requests in its innovation strategy and develops services that serve the needs of patients, taking into consideration their demands. This is consistent with the findings of Nicolajsen and Scupola’s (2011) study, which argues that customers play a critical role as to the degree of service innovation, helping firms to achieve higher levels of radical innovation. Still, the management teams of the case hospitals argued that patients are able to play a role in the enhancement of hospitals’ residential services, but not in the development of medical ones. Hospital managers underlined that only some of mental service users are in a position to contribute to the development process. However, there were respondents who stressed that in psychiatric centres, there is no such culture and organisation as might care about customers’ desires and
integrate these into the service development process. The above analysis illustrates well that
the current structure and organisation of some case hospitals do not work in favour of either
business development or new service development. It becomes also clear in the analysis of
the findings that there is no central and specific plan for innovation, being a negative factor
for innovation development.

7.3 Entrepreneurial activities and corporate venturing objectives of
case hospitals

This section discusses and compares the answers of top executives of the case hospitals. It will
set the background for RQ4 – “How and to what extent is corporate venturing developed by
adopter service innovation initiatives?” Overall, it emerges that hospital managers are quite
autonomous in making decisions regarding the expansion of offerings, whether creating a new
department or developing a novel service, aiming to better meet the needs customers and
enhance service quality. Entrepreneurial activity acts as a key contributor of economic
development and growth at different levels. Significant inputs from entrepreneurs to
economic growth are mainly attributed to an accelerated path of creation (generation),
diffusion (dissemination) and application of innovative ideas (Butel and Watkins, 2006).
Though it is claimed that entrepreneurs are spontaneously not interacting in a cooperative
manner, networks of innovators are reportedly developing over time based on an interest in
similar opportunities. Previous contributions have demonstrated that random search for
resources in the business environment does not constitute a successful endeavor (Butel and
Watkins, 2006). Thus, one of the primary advantages of external networks is the rapid
identification and availability of resources in the environment. In addition, it seems that the
administration teams of the Saint Irene and Eleftheria hospitals promote entrepreneurial
ideas that seem to have both caring and financial return, whereas the other three hospitals
seem to focus more on the ways to tackle current economic crisis, rather than to invest in new
areas of mental healthcare. Nevertheless, most of the examined hospitals reward both
executives and scientific personnel for successful innovation efforts, offering economic
bonuses, business prospects, and sometimes project funding. Consequently, it comes forward
that some case hospitals exploit service innovation to engage in venturing activities, as every
investment is undertaken so as to develop a new offering to improve quality and meet further
needs, and to expand the companies’ activities to address potential customers, increasing
their target groups. Supported by the study of Baum et al. (2013), growth orientation, innovation, and knowledge exploitation lead to higher levels of customer satisfaction and sustainable development.

7.4 Patient involvement and health service innovation in case hospitals

This section aims to match and compare the answers of top executives and hospital managers of the examined organisations with those of the medical personnel. This will set the background for RQ1, RQ2 and RQ3 – “Where, how and why should patients be involved in new service development?”, “How do medical personnel perceive patient involvement in new service development?”, and “What is the role of medical personnel in patient-oriented service development?” Following the findings of Love et al.’s (2011) study that business growth derives from both service innovation and diversity of innovation, data show that some of the hospitals have been well developed over the past two years, introducing new services, creating new departments and developing new collaborations with scientists to expand firms’ activities. It is noteworthy, however, that the hospital manager of Thermaikos and the CEO of Galini mentioned that their hospitals have not developed a new offering in the industry, even though it emerges that both hospitals have taken significant steps, either upgrading infrastructure and enriching their services or developing new ones, aiming to better meet customers’ needs and improve their competitiveness.

Additionally, Saint Irene and Castalia are keen to expand their activities in the sector of mental healthcare by adopting new practices and creating new structures that will contribute to patients’ treatment and reinforce deinstitutionalisation. Here, it becomes apparent that these hospitals recognise the gaps in organisation and structure, showing willingness to adopt processes that will improve performance. According to Rademakers et al. (2011), by identifying limitation in organisational structure and processes, it benefits both society and the hospitals’ positioning in the market place. It also arises that their plan is to expand the services, targeting a wider range of patients. Overall, it comes to attention that ideas for growth come mainly from administrative and scientific personnel and less from customers and market research. In addition, the competition’s actions and the evolution of science both play an important role in decision-making, as supported by Teodorescu and Usher (2013). Furthermore, it turns out that coordination between departments, in new
service development, needs to be improved. Few are those who argue that mere interaction of individuals offers optimal results, as it causes problems as regards: communication between hospitals and central offices, cooperation of clerical with medical staff, and collective action among scientific personnel relating to the selection and design of the new offerings. It is worth noting that Castalia hospital has achieved high level of cooperation among staff, through creative exchange of views and joint decision-making. The latter comes forward the business culture issues that the organisation has to solve, as they appear to affect negatively both business and new service development (Efrat, 2014; Bock et al., 2012).

This research concludes that the examined hospitals adopt procedures to assess the market, utilising a number of tools (reports, statistics, market research, observation of competition, doctors’ collaboration, and more). Particularly, Saint Irene and Castalia seek information on demographic and social characteristics; the economic background of the local community; the condition of the competition and unmet needs; the cost of the potential venture; possible financial gain; and the existence of scientific personnel in the community. Reid et al.’s (2014) study explains that market visioning and assessment is important for firms to achieve radical innovation outcomes. In addition, it appears that in most cases interdepartmental meetings take place regularly to discuss industry development and market trends. It also emerges that all hospitals aim to establish firm relationships with associated doctors and with customers, although the operational framework sets doctors as mediators in the hospital-patient relationship. In addition, customers’ opinions are taken seriously, so special service teams are formed within hospitals to improve service provision and raise customer satisfaction. This shows the positive effect of customer requirements in service improvement and new service development. This is consistent with the findings of Zhou and Li (2012), and Fang et al.’s (2011) studies that market knowledge acquisition and customer participation have positive influence on innovation and firm performance. Despite all the deficiencies, the companies strive to adopt techniques for monitoring queries and complaints from customers and create mechanisms that incorporate them in designing new services and stimulating initiatives for growth. Nevertheless, it is worth noting that while there is no particular flexibility for customisation, it seems that many executives support further patient involvement in the development of new services and declare that such practices and methods should be adopted.
It becomes apparent that hospitals seek to build a relationship of trust with customers by providing high-quality healthcare, arranging recurrent sessions with psychiatrists and other doctors, and maintaining continuous communication with both patients and relatives. This proves that the good customer involvement experience has a positive effect on new service development (Mahr et al., 2014). Nonetheless, it is evident that none of the hospitals uses formalised tools to assess customer satisfaction or a process to track and respond to customer queries or a method where complaints trigger growth initiatives. Nor are there mechanisms through which the views of customers may be included in the process of designing new services. Absence of such methods may hinder the innovation activity of firms, as customers’ insights would not be incorporated in service development processes (Rego et al., 2013). Still, the scientific personnel that participated in the research emphasised the importance of customisation in mental health, indicating that the needs of every patient differ significantly. In contrast, the manager of Galini hospital states that services should be provided in the same way to all patients. It is also important to note that respondents agree and suggest various ways to strengthen the presence and participation of patients in the innovative activity of hospitals. Some suggestions concern the development of activities that will increase patients’ involvement (i.e. participation in everyday hospital work, occupational therapy with social benefits etc.). Such initiative are likely to increase the levels of patient satisfaction, and help the mental service users to progress with their health conditions (Tambuyzer et al., 2014). Finally, many noted that an organised effort on the part of the company would have outstanding results for patients, as also supported by the findings of Robertson et al. (2014). For example, patients would understand the importance of their involvement and the strength of their opinion through discussion and cooperation with medical staff. Overall, the analysis indicates that no such organised activities are carried out, with occasional exceptions.
7.5 Comparison of research findings with theory

Many researchers have studied service innovation, corporate venturing, and customer orientation as shown in Tables 2.7 and 2.8. In Table 7.1 (modified from those Tables), the categories related to the key concepts of this study are pooled from other researchers’ findings. Key concepts in this study were modified from these categories to be commensurate with the nature of the healthcare industry. The research findings in previous sections revealed twelve groups of key concepts as having causal relationships with innovation, corporate venturing, internal resources, external networks, new service development, and customer orientation and involvement. Several researchers have studied the importance of innovation in business operations and growth. For example, Svendsen et al. (2011), and Rehme and Svensson (2011) report that innovation leads to organisational growth, change and improves...
firms’ competitiveness. Likewise, research phase 1 of this study confirms this point as it found that innovativeness influences organisational sustainability and value creation. In particular, service innovation is of great importance for healthcare companies as it improves personnel’s expertise and development, while boosts customers’ satisfaction. This is valid especially when proper procedures and approaches are followed. Those findings are consistent with other researchers, who argue that service innovation is a key element of customer creation (e.g. Gustafsson et al., 2012; Perks et al., 2012). Similarly, studies have shown that organisational innovation improves business culture and organisational structures (e.g. Bock et al., 2012; Naranjo-Valencia et al., 2011). The findings of this study confirm that as many respondents considered organisational innovation as the factor, which advances structures, culture and policies. Additionally, this research shows that corporate venturing leads to business development and organisational renewal, which is consistent with the studies by Narayanan et al. (2008), and Korsgaard and Anderson (2011). Likewise, internal resources, external networks, and knowledge acquisition enhance companies’ ability to create value, new knowledge, and, therefore, grow. This study supports those findings, as it showed that employees, medical staff and other stakeholders are a valuable source for knowledge-based value creation.

Furthermore, this study found that new service development is essential for business growth, opportunity generation, cost reduction, etc. This is also confirmed by other studies (e.g. Storey and Hull, 2010; Cooper and Edgett, 1999). Finally, it is well developed in the literature that customer orientation benefits companies as it allows them to identify better customers’ needs and create customer value (e.g. Witell et al., 2011; Malhotra and Kubowicz-Malhotra, 2011). This study is consistent with this as it found that customer involvement is likely to increase service quality and customer satisfaction. Likewise, patient involvement leads to patient-focused new service development, motivates service users, and enhances knowledge transfer between users and medical staff (e.g. Robertson, 2014; Straus et al., 2013). This is also confirmed by this study, which found that users’ behaviour improves when they are involved in such processes as they feel that they benefit themselves.
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### 7.6 Summary of the findings

A summary of the findings is presented below in Table 7.2. Following this chapter, the contribution and conclusion of this study are presented in Chapter 8. The implementation of all significant factors is also recommended.
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<th>Questions</th>
<th>INNOVATION: Activity, factors, and business culture</th>
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<tbody>
<tr>
<td>1. What are the internal factors that predispose the organisation to seek access to innovation?</td>
<td>Evolution of technology; attitude of managerial and scientific staff towards innovation; evolving needs of patients; the quality of the service offerings; the need to remain competitive and have additional revenue from different sources in a time of crisis.</td>
</tr>
<tr>
<td>2. How and to what extent do external factors such as legislation, social and economic, condition or stimulate favourable attitudes towards innovation?</td>
<td>Legislation, finance, and social factors appear to hinder firms that operate in the Greek healthcare industry. In particular, regulations change too often, the business environment is fluid, the financial crisis deters innovation, and meeting social factors does not offer commensurate economic outcomes.</td>
</tr>
<tr>
<td>3. Are adequate tools and processes used to generate opportunities for product development?</td>
<td>Several tools are used by the company to identify the needs of customers and assess the healthcare market, (i.e. management information systems and questionnaires). However, those tools have not been adopted by all psychiatric hospitals, as managers recognised that they do not use appropriate tools that help the development of new offerings.</td>
</tr>
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<td>4. Does the organisation do enough to create:</td>
<td>Top executives and hospital directors argued that their units attempt to develop a business culture where everyone could undertake initiatives to enhance service quality, meet customer requirements, decrease operating costs, generate new ideas for expansion, promote service products, and develop beneficial relationships with the community. On the other hand, medical and nursing staff complained that no such actions take place and the firm is far off its targets.</td>
</tr>
<tr>
<td>i. A culture where continuous improvement is regarded as a norm?</td>
<td>The case hospitals engage customers’ requests in their innovation strategy and develop services that serve the needs of patients, taking into consideration their demands.</td>
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<tr>
<td>ii. Incentives for staff to identify and act on opportunities for improvement?</td>
<td>Patients are able to play a role in the enhancement of hospitals’ residential services, but not in the development of medical ones. Hospital managers underlined that only some of mental service users are in a position to contribute to the development process.</td>
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<td>5. How adequately or appropriately are the requirements of customers taken into account in organisation’s innovation strategy?</td>
<td>The case hospitals appear to be not rigorous about efforts that fail. They prefer to gain knowledge from such events, to improve its assessment techniques and increase the chances of success for future attempts. Consequently, the role of top executives and medical personnel is critical regarding the adoption of innovation and the reinforcement of the service development process. Still, there is scope for improvement, as many highlighted that there are gaps regarding staff participation in the decision-making process and their cooperation with administration.</td>
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<td>6. Do you believe that customers/patients can contribute something extra to the service innovation process?</td>
<td>The stimulus of growth advances innovative activity and some case hospitals have proved that their entrepreneurial goal is to expand their operations, developing novel services that fulfil customers’ growing needs.</td>
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<td>7. What do you think is the role of the top executives/medical staff in promoting the internal innovation process?</td>
<td>Some executives argue that their firms have built a system where innovation flourishes without constraints. Most respondents, however, believe that further actions should come about to upgrade organisations’ structure and attain better outcomes.</td>
</tr>
<tr>
<td>8. Do you believe that the stimulus of growth could help you become more innovative, developing new services and approaching new markets and why?</td>
<td>The case hospitals have been actively developed over the past two years, introducing new services, creating new departments and developing new collaborations with scientists to expand hospitals’ activities. It is clear, however, that further actions are needed as to the involvement of patients in the growth initiatives.</td>
</tr>
<tr>
<td>9. Do you believe that the organisation and the structure of the hospital help you to implement innovative actions? If so, how does this happening?</td>
<td>The case firms are keen to expand their activities in the sector of mental healthcare by adopting new practices and creating new structures that...</td>
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**NEW SERVICE DEVELOPMENT: Process, service improvement and evolution, and coordination**

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<th>Questions</th>
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<td>10. Did the organisation introduce any new or significantly improved service in mental health sector?</td>
<td>The case hospitals have been actively developed over the past two years, introducing new services, creating new departments and developing new collaborations with scientists to expand hospitals’ activities. It is clear, however, that further actions are needed as to the involvement of patients in the growth initiatives.</td>
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<td>11. How many new services did you introduce last year?</td>
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<td>12. How and to what extent has your service products changed during the past 2 years?</td>
<td></td>
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<tr>
<td>13. Does the organisation have a plan for the extension and evolution of its services?</td>
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14. Where did the concept of developing new services come from? (existing customers, new customers, market research, always part of the plan?)

Ideas for growth come mainly from administrative and scientific personnel and less from customers and market research. In addition, the competition’s actions and the evolution of science both play an important role in decision-making.

15. How would you evaluate the coordination among people and departments throughout the new service development process?

Coordination between departments needs to be improved. Few are those who argue that mere interaction of individuals offers optimal results, as it results in problems as regards: communication and cooperation between administration and medical personnel, and collective action among scientific personnel relating to the selection and design of the new offerings.

16. Will you please describe the venturing and entrepreneurial activity in the organisation?

Overall, the hospitals explore opportunities that emerge from the requests of customers or doctors. Some case hospitals appear to be based on the demand-led provision concept.

17. What are the hospital’s venturing objectives?

Hospitals’ goal is to expand their services into other sectors of healthcare, i.e. rehabilitation sector, and also develop a small network of primary mental healthcare settings that will cover the needs of the wider region, achieving maximum population coverage.

18. How are entrepreneurial opportunities identified, evaluated and selected by the organisation?

The case hospitals promote entrepreneurial ideas that seem to balance the caring and financial return. Entrepreneurial opportunities are identified by market research and evaluated by hospitals’ executives, and doctors. They decide which opportunities worth exploring according to the needs, the competition, and the current economic situation. Following this, industrial reports show which sectors will continue growing in the near future.

19. How does the organisation encourage and support entrepreneurial activity? How does recognise and reward innovative efforts?

The companies reward both executives and scientific personnel for successful innovation efforts, offering economic bonuses, business prospects, and project funding.

20. What preliminary market assessments occurred before any investment was undertaken? (market research, market segmentation)

The case hospitals assess the market, utilising a number of tools (reports, statistics, market research, observation of competition, doctors’ collaboration, etc.)

21. Is there a clear idea of the type of information to be obtained through market assessment?

The companies seek information on demographic and social characteristics; the economic background of the local community; the condition of the competition and unmet needs; the cost of the potential venture; possible financial gain; and the existence of scientific personnel in the community.

22. How much time and effort is spent in conducting interdepartmental meetings to discuss market trends and developments?

In most cases, interdepartmental meetings take place regularly to discuss industry development and market trends, and design strategies for future developments.

23. What type of relationship does the organisation have with its customers?

The case hospitals aim to establish firm relationships with doctors and with customers. Additionally, customers’ opinions are taken seriously, so special service teams are formed within hospitals to improve service provision and raise customer satisfaction.

24. Is there an adequate process to track and respond to customer queries and complaints? If so, does management get an up to date of the status of complaints?

None of the hospitals uses formalised tools to assess customer satisfaction or a process to track and respond to customer queries or a method where complaints trigger growth initiatives. Nor are there mechanisms through which the views of customers may be included in the process of designing new services. Only informal meetings among departments are conducted to discuss such issues.

25. Is there a robust mechanism to integrate the views of customers into the service planning process?

Respondents emphasised the importance of customisation in mental health, indicating that the needs of every patient differ significantly.
Therefore, numerous methods are employed to take patients’ demands into account and customise offerings based on specific needs.

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<th>27. Please determine the ways by which the hospital can increase customer involvement in its innovative activity.</th>
<th>Respondents agree and suggest various ways to strengthen the presence and participation of patients in the innovative activity of hospitals. Some suggestions concern the development of activities that will increase patients’ involvement (i.e. participation in everyday hospital work, occupational therapy with social benefits, etc.).</th>
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<tr>
<td>28. Are there measures of customer satisfaction that you use to improve your services?</td>
<td>No such measures exist or organised activities are carried out, with occasional exceptions, but informal discussions with practitioners take place. Overall, customer participation in new service development activities is poor, even though the case hospitals recognise its importance.</td>
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CHAPTER 8
CORPORATE VENTURING DYNAMICS AND PATIENT INVOLVEMENT IN MENTAL HEALTH SERVICE INNOVATION

CONTRIBUTION AND IMPLICATIONS OF THE STUDY

The world of private health institutions confronts a great deal of competitiveness. Smaller companies are overwhelmed by their “bigger” competitors after (having faced) a series of significant business evolution and turmoil that induced investments, changes in ownership statuses as well as contracts and partnerships. The “giants” of healthcare groups offer a significant variety of medical services while focusing, at the same time, on covering the needs of large geographical areas and on evolving both scientifically and technologically. Thus, the emergence of business challenges, as it has already been mentioned, is expected, and business expansion derives from the competitiveness governing the healthcare market. Thereby, the contribution of competition to the growth of new health services is understood and can be also verified from the conclusion of Chapter 3. Moreover, business development is generated by the progress of medical science and technology, and by the demanding needs of patients.

Furthermore, patients’ active involvement in the process of their medical treatment, by accessing information and alternative therapies, reveals their participation in the overall function of healthcare establishments. The study of the positive results of this active participation of the service recipient that can boost business activity and can contribute to the provision of new services was the purpose of this study. First of all, the present study aimed at setting forward previous service innovation theory by correlating it with entrepreneurship theory and, moreover, it intended to expand previous theories concerning the advantages of customers’ participation in new health service development. This research’s originality and importance lies in the combination of a theoretically documented framework which serves as an identification area for estimating the positive effects of patients’ active
inclusion in healthcare services towards the establishment of new both customer-friendly and profitable services.

This research’s main topics have been approached at two main stages. One of them is the theoretical codification of the innovation and entrepreneurship literature as well as the evaluation of main results within the framework of this theoretical codification and the development of patient-oriented services. The other is the inferences that arise from this research as far as it concerns case-study establishments and theoretical texts. Table 8.1 recapitulates the outcomes of this research presenting the responses to the research questions along with the details of the propositions. Also, the present research’s restrictions and the perspective of a future research are examined in this chapter.

8.1 Contrast between key findings and research questions

This section presents the conclusions for the four research questions that have been analyzed in Chapter 1. The research questions below are answered in the following subsections of the chapter.

RQ1: Where, how and why should patients be involved in new service development?

RQ2: How do medical personnel perceive patient involvement in new service development?

RQ3: What is the role of medical personnel in patient-oriented service development?

RQ4: How and to what extent is corporate venturing developed by adopting service innovation initiatives?

8.1.1 Service innovation activities in case hospitals

The principal constituents (i.e. technological progress, assistance provided by personnel and customers, quality of service provided, need for a competitive company profile) that give innovation incentives to an enterprise are disclosed by the conclusions of this research. The importance of customers’ implication in new products’ design and development is
acknowledged by many studies (e.g. Korschun et al., 2014; Witkowska and Lakstutiene, 2014; Grissemann et al., 2013). Staff effectiveness also boosts the level of commercialization (e.g. Wei et al., 2014; Jin et al., 2010). On the contrary, social turbulence, the economic situation and legal restrictions constitute crucial constraints that hinder businesses from adopting and promoting innovative practices (e.g. Carayannis et al. 2014; Håkansson and Waluszewski, 2014). Additionally, studies show that, although companies tend not to follow politically correct procedures to develop new services, a legal and formal series of actions leading to innovation can guarantee innovative services’ establishment and legally valid function (e.g. Gremyr et al., 2014; Weber and Van der Laan, 2014). The above-mentioned conclusion is also underlined by many studies, which stress the significance of a meticulously organized process in increasing the odds of success of a newly established service (e.g. Edvardsson et al., 2013; Elget al., 2012). Thus, companies that abide by systematized procedures during their attempt to develop new innovative services are more dynamic than their less successful rival companies (Autio et al., 2014; Bowers and Khorakian, 2014; Mahr et al., 2014). As Audretsch et al. (2013) mention it in a study; creative companies differ from the less innovative ones in that they apply formalities during the development procedure of new services. Similarly, Jin et al. (2010) notes in one of his studies that a firm’s risk control, as well as development cost and time reduction can be achieved by following formal innovation procedures. Another important factor, which results from following a standardized formal development program, is the ability to assess the staff’s competencies. Another important point is added by Oke’s studies (2002, 2007) where the importance of involving the company personnel in the innovation process through certain strategies is emphasized. Edvardsson’s and Enquist’s (2011) theory underlines the adversities faced by businesses that attempt to apply standard procedures; these adversities result from in-company lack of organization and structure. This is also the case for the examined health institutions, which admit having inefficient structures and organizational deficiencies.

Besides, it was agreed by the case hospitals that novelty is the main parameter leading to the longstanding development and economic success of businesses; this fact is also supported by the studies of Brem and Borchardt (2014), Carayannis et al. (2012), and Eisingerich et al. (2009). Also, the importance of customers’ involvement, according to their
needs and demands, in the design and growth process of firms is stressed by some studies (e.g. Feng et al., 2012; Fuchs and Schreier, 2011; Svendsen et al., 2011).

8.1.2 Entrepreneurial activities and corporate venturing objectives of case hospitals

As is also mentioned in a number of studies concerning entrepreneurship (e.g. Alegre et al., 2013; Vega et al., 2013; Salavisa et al., 2012), the results of the present study have also led to the conclusion that certain principles, such as novelty, economic growth through creation of new products, adoption of new processes and investments in business development, are the success factors that interest examined hospitals, which seek to foster entrepreneurship so that they benefit from business opportunities efficiently and respond to patients’ needs. It is declared by some studies (Battistini et al., 2013, Dokko and Gaba, 2012, and Nasution et al., 2010) that entrepreneurship is all about discovering and taking advantage of circumstances that favor profit as well as customer needs’ identification. Some other studies focus on the fact that corporate venturing activities, which show the way to business growth, are accomplished by starting new entrepreneurial activities within an already existing company and are connected to innovative initiatives and corporate renewal (e.g. Baum et al., 2013; McGrath et al., 2012). Findings show that the examined health institutions embrace the aforementioned policy. All these consent to the second proposition, which claims that a greater number of ignored entrepreneurial opportunities will be revealed once a healthcare organization incorporates new services into its business growth process. All these consent to the second proposition, which claims that a greater number of ignored entrepreneurial opportunities will be revealed once a healthcare organization incorporates new services into its business growth process.

8.1.3 Patient involvement and health service innovation in case hospitals

It has been proved by the research that the examined healthcare institutions embrace new strategies and develop innovative services that respond to customers’ treatment needs to achieve activity growth in the mental healthcare sector. Other studies (Avise et al., 2014, Ennis and Wykes, 2013, and Rademakers et al., 2011) acknowledge that firms that focus on customer satisfaction offer a higher level of services. Moreover, concepts for further growth are attributed to administrative and scientific personnel rather than to customers and market
research. This finding is the reply to the third research question in that it underlines the crucial role of medical staff in the development of services focused on patients’ needs and demands. However, Hoyer’s study (2010) expresses a different view which claims that patients’ contribution to the development of new customer-oriented services is necessary, constitutes source of inspiration for the creation of new services that can fulfill unmet needs and, at the same time, when applied successfully, it promotes productivity and effectiveness. These validate the third proposition, which supports that patients’ involvement in the idea finding procedure will generate more new service options. Additionally, all examined healthcare institutions seem to tend towards building strong bonds with doctors and patients, while in Greece doctors are considered as mediators between the hospital and persons being treated for medical problems. A number of studies show that customers, both clients and doctors, contribute as resources, co-producers, buyers and users (e.g. Tambuyzer et al., 2014; Bellou, 2010; Lundkvist and Yakhlef, 2004) and this is also supported by Mockford et al. (2012), who claim that cooperation between hospitals and customers, such as therapists, patients, etc., is necessary so as to create and carry out projects which reinforce customer satisfaction and the quality of offered services.

Furthermore, findings prove that case hospitals are interested in taking into consideration customers’ positive and negative comments so as to enhance their services and follow the path of development and further evolution. As several studies (Feng et al., 2012, Blocker et al., 2011, and Tajeddini, 2011) suggest, customers can be active and effective participants in the process of planning and development by selecting the appropriate design solutions and interest specifications. This argument is also evident in part of the findings of Veryzer and de Mozota’s study (2005), where it is stressed that the formation of new products is influenced by a user-friendly orientation and design. Thus, all the aforementioned validate the fourth proposition, which suggests that involving patients in the service development process will facilitate healthcare companies to implement services that respond to patients’ needs. Patients’ inclusion in the development of new services is also supported by many executives who claim that such methods should be adopted by healthcare firms; this signifies that customers’ active involvement in new service development has not been established yet. According to a study by Berry and Mirabito (2010), health services must be accustomed to taking into account individual patients’ medical needs and as Groen et al. (2014) stress, the
connection between patients and healthcare organizations should be considered so as to assess if service users respond to treatment. Besides, patients’ participation in hospitals’ innovative projects is acclaimed and is considered crucial by firms that participated in this research and which have also suggested various ways to increase patients’ assistance and input on hospitals’ innovative steps. This finding answers the second research question in that it confirms that medical personnel consent to patients’ involvement in the implementation of innovative activities. Likewise, Robertson et al. (2014) allege that patient participation means interaction between individual users and therapists, management of local services, and services’ development.

It is obvious that patients’ involvement in health institutions’ new service development projects is expanding. However, Alves et al. (2013) allege that it is crucial that health service firms ensure patients’ “safe” involvement in the innovative activity by providing them with adequate training and by eliminating stress factors that might derive from the procedure. Similarly, according to the studies by Kelly et al. (2012), and Thompson and McCabe (2012), health service providers must collect and use information so as to better respond to customers’ needs by eliminating customer complaints and by improving levels of customer satisfaction. It is evident that none of the case healthcare institutions apply any of the assessment tools and methods that will judge the degree of customer satisfaction, lead to solutions inspired by patients’ complaints or enable them to take into account service users’ opinions for the planning of new services. As a result, this verifies the fifth proposition that healthcare organizations will be able to discover numerous development options through the implementation of new mental health services in the framework of exploiting entrepreneurial opportunities.

8.2 Critical review of key models developed in the study

The present study provides theoretically and practically sustained research; thus, it enriches related literature in two critical ways, one of them being a fruitful theoretical framework and the other a new entrepreneurial model. An assessment of these two principal axes is presented in this section.
The theoretical foundation of this research (Figure 4.13, Chapter 4) presents a new viewpoint to the literature of innovation and entrepreneurship. This study enriches the already existing studies since it examines combinations of theories not having been analyzed thoroughly before. The study reviews relevant literature on customer-driven service innovation and corporate entrepreneurship, identifying a knowledge gap within the field of patient orientation in new service development and within the emerging trends of business development in mental healthcare. This gap highlights the importance of an integrated model, which would illustrate the customer dynamics at the firm level. This finding is consistent with the implications of several studies that have pointed out the need for such model, describing the antecedents and outcomes of collaborative innovation dynamics (Carayannis et al., 2014; Håkansson and Waluszewski, 2014; Robertson et al., 2014; Wei et al., 2014; Evald and Senderovitz, 2013). In general, the promotion of innovative enterprises and the implementation of new customer-oriented health offerings constitute neglected fields of research (e.g. Sharma et al., 2014; Svendsen et al., 2011; Rehme and Svensson, 2011). The literature’s study has proved that those topics have not been examined simultaneously although customers’ contribution can have a determining impact on the development of new services that may enhance entrepreneurial activities. As far as it concerns the Greek healthcare market, it seems that no similar research has been administered before. To sum up, the theoretical framework and the customer-driven innovation framework for entrepreneurial growth include these theories and examine their combination and development from an alternative viewpoint.

The contribution of this study builds upon the existing knowledge by acknowledging and integrating the dualities at play within organizations into a single framework: service innovation, corporate entrepreneurship, and patient orientation dynamics. The combination of these concepts has been overlooked in previous attempts to conceptualize patient-driven service innovation and other knowledge dilemmas and tensions within organizations. These two dimensions have rarely been co-examined at the micro levels, whereas, in contrast, patient orientation is identified as a stream of future research in innovation management (e.g. Mahr et al., 2014; Tambuyzer et al., 2014). This study adopts a multi-level approach to describe and analyze service innovation dynamics in intra-organizational settings and offers a better understanding of the phenomenon via the conceptual framework and the customer-
driven innovation framework for entrepreneurial growth. The most recent studies that have examined the role of customers in new service development process are those conducted by Sharma et al. (2014), Fuchs and Schreier (2011), and Svendsen et al. (2011). The customer-driven innovation framework for entrepreneurial growth (Figure 4.15, Chapter 4) shows patients’ input on opportunities identification and their participation in the development procedure. The above-described model contributes to knowledge regarding health services’ evolution as it displays the necessity of patients’ participation. The deficiency of research and outcomes on this significant topic has been observed in Chapter 2. Many studies deal with the interaction between innovation and corporate venturing (e.g. Titus et al., 2014; Battistini et al., 2013). What is different about the present theoretical framework is that it underlines the interconnection between the two concepts and the way this relation contributes to the identification and exploitation of business opportunities. This study has attempted to advance current knowledge of corporate venturing dynamics and patient involvement in service innovation by introducing and examining several collaboration modes in this value creating ecosystem: knowledge emergence through the collaborative dynamics of patient involvement, service innovation, and business development and expansion through corporate venturing explorations. Besides, the knowledge-based perspective used to analyze the potential of service innovation at the firm level brings a first representation of how knowledge and value creation is achieved and sustained through customer-oriented innovation strategies. The argument further advances theory aiming to reinforce organizational sustainability by mapping the competitive, yet collaborative dynamics in and around healthcare organisations. Henceforth, the conceptual framework can be seen as a new theoretical lens for innovation management studies, examining the impact of customer orientation on service innovation and business development mechanisms within organizations. This first contribution of the study leads to other contributions related to the analysis of firm’s innovativeness as well as mechanisms of customer involvement in business growth and development. In this regard, the present study represents a step forward in innovation research as it provides new perspectives of a knowledge-based view of customer-driven service innovation. Overall, the conjunction of different theories and activities to generate new business ventures through the development of new services is accomplished. Consequently, both the theoretical foundation and the customer-driven innovation framework for entrepreneurial growth presented by the present research offer, for the first
time, a complete depiction of the innovative service development and entrepreneurship controversies.

8.3 Research assessment – Contribution of the study

The study’s input and conclusions are presented in the following sections.

8.3.1 Originality and theoretical implications

Research on service innovation and corporate entrepreneurship allows to derive practical conclusions, which can serve as the basis for an improved and enhanced implementation of customer-oriented new service development in the healthcare system. The findings of this research indicate that business-venturing opportunities regarding product and service novelties, such as new structures and innovative health services, or business growth, meaning expanding to new markets and other healthcare fields, derive from strong competitiveness. By taking advantage of this kind of entrepreneurial opportunities, health service firms become stronger and stay competitive since they provide services to more customers and gain larger market shares. This research contributes to existing theories by underlining the importance of expansion, progress, novel services’ development, essential investments, and exploitation of business opportunities in firms’ success. This finding verifies the first proposition that more business openings will be pinpointed as a result of the strong competitiveness in the healthcare market. Equally important are the conclusions drawn from the effect of the economic crisis on the fate of service innovation and business development in healthcare. Some researchers who support that entrepreneurship is a vehicle for exiting the crisis (Papaoikonomou et al., 2012). In contrast, others profess that the customer orientation shall not be considered as mechanisms to lead to economic recovery (Homburg et al., 2011).

This study aimed to examine the theoretical background of entrepreneurial innovation and customer orientation in healthcare providing valuable insights into introductory concepts, types, and forms of such activities and resulting advantages and disadvantages. It also illustrates the dynamic view of patient involvement in the private healthcare sector, with business, and social actors influencing the development and prosperity of such initiatives. This contribution fills the knowledge gap of cooperation dynamics, entrepreneurship, and
innovation that is likely to emerge from innovation initiatives that adopt customers’ suggestions, aiming at addressing social challenges. Moreover, it has been confirmed that immediate interaction exists between the notions of innovation and entrepreneurial success. Other significant points that have been formed in this study show:

1. Technology’s effectiveness regarding innovative ventures
2. Clientele’s essential input on the success of new offerings
3. Motivation for innovation offered to mental healthcare firms by quality services and intense competition
4. Mental healthcare institutions being deterred from applying innovative projects because of the present social turbulence, complicated legal regulations, and existing financial situation.

The key configurations presented in the study examine the disposition of healthcare firms to use internal and external sources of entrepreneurial innovation as a competitive advantage by focusing on business relationships issues, such as challenges related to the development of innovation in a customer-oriented context. This study, therefore, adds value to the literature of service innovation and corporate entrepreneurship by examining and considering the role of individual actors (i.e. medical personnel and patients) in the exploitation of business opportunities through the development of customised new offerings and the emergence of knowledge-based interactions among partners. In this context, it comes forward that organizations should identify and consider practical ways to manage innovation initiatives - both at an organizational level and at the individual and team level -, to maintain their competitive advantage. Based on this, an important implication relates to the mechanisms by which innovation is developed and diffused within the organization, among different entities, and across boundaries. In this regard, the study answers calls to integrate the notion of boundaries and obstacles in studies of healthcare innovation and entrepreneurship (e.g. Autio et al., 2014; Efrat, 2014; Groene et al., 2014; Mahr et al., 2014; Robertson et al., 2014; Guerrero and Peña-Legazkue, 2013). The outcomes of this study also contribute to other studies’ conclusions (Lerro et al., 2012; Nasution et al., 2010) as they verify that entrepreneurial activities help firms satisfy customers’ demands. As far as customer involvement is concerned, it has been noted that this contributes to the development of new
offerings, assisting hospitals in promoting their business activities. Moreover, this research validates other studies in that it confirms companies’ need for customers’ active inclusion in the process of implementing new outcomes. This technique would enable businesses to comprehend their customers’ needs and requests and, at the same time, adopt mechanisms that would allow them to keep track of their customers’ requirements, inquiries and degree of satisfaction and use them as a source of inspiration for new development projects. This procedure could serve as a way to exploit new business openings and to implement new services that focus on customers’ needs. This research also stresses the significance of patients’ participation in the innovative process since their assistance in the formation and application of new creative projects can lead to the provision of new health services that are adjusted to customers’ real needs and demands.

In general, although medical and nursing personnel in the examined healthcare institutions held a positive attitude towards the idea of involving customers in mental healthcare services, they expressed doubts as to whether mental health patients are capable of contributing constructively to the formation and realization of such services. One of the doctors implied, “Doctors and nursing staff should continue the same pattern of conduct and communication with patients as it is successful and functional. Patients have not expressed major complaints or dissatisfaction after all.” This wary attitude towards the necessity of boosting user involvement in policymaking procedures, which results from the lack of visibility, voice and reliability within mental health institutions, leads to the impediment of establishing service user participation in practice (Woodhouse, 2010). As it is mentioned in several studies, professionals’ opinions differ from what happens in practice (O’Brien et al., 2013; Shortus et al., 2013). Many of them do not seem to trust the opinions of mental health patients because of their diagnosed inability or unwillingness to express their needs and requirements. This aspect has been traced among managers and senior staff mental health documentation shows that patients become interested in participating in formal procedures as long as the staff is adequately trained to provide support, which will enable patients to stop feeling excluded, intimidated, and stigmatized.

Inconsistencies in mental healthcare services are attributed to executive scientific personnel and high-rank managers who believe that they possess power and exert authority
within hospitals (Rise et al., 2013; Stromwall et al., 2011). The findings of the present research confirm this fact as well. This mentality can obstruct attempts towards more efficient customer involvement as it is based on “the principles of servitude and dedication with a rigid hierarchy that breeds rigid beliefs” (Hampshire, 2000, p. 10). Nevertheless, the examined health institutions seem to be flexible and independent without abiding by the principles of authoritarian management structures. The interaction between medical personnel, nursing staff, and patients appears to establish a good level of cooperation and understanding of their collaborative work’s nature, value and significance. This finding is a meaningful conclusion because several studies in the related literature associate medical staff’s opposition to the fact that restrictions are set to user empowerment (Bellou, 2010; Summers, 2003). However, some medical employees are not willing to take into consideration patients’ opinions since they do not consider them capable of participating in service innovation practices. Professionals are seriously concerned about the ‘representativeness’ of users (Ennis and Wykes, 2013; Staniszewska et al., 2013); a fact that has been identified in this study, too. This finding presents an attitude that may become a source of doubts for users to question their representativeness (Alves et al., 2013), but this is not the issue in this study.

The theoretical framework of this research is one of its main contributions to future researchers since it can serve them as a base on which they can create their potential research attempts. The present study firstly mentions the definitions of innovative healthcare concepts and a detailed explanation of new mentalities in the healthcare sector. Thereafter, the theoretical framework is elaborated, mentioning the most significant variables that affect innovation in contemporary healthcare systems in Greece. Founded on the initial definition of healthcare innovation, all relevant parameters of healthcare novelty, as well as its procedure and theoretical framework, are stated among others in this study. This paper’s aim is to assist researchers in clarifying numerous inquiries concerning healthcare innovation perspectives. The key to the implementation of radically innovative ideas and solutions in the healthcare sector is the clarification of the actual concept of innovation, which once is achieved, it can, and then, facilitate health policy makers and medical executives to establish and embrace new offerings that boost effective and original innovative activities. Qualitative research and design philosophy are the main constituents of this approach, which aim at identifying all opportunities for innovation, and apply strategy skills to suggest valuable solutions with
measurable end user value. As indicated by other studies, it has proved relevant in other business procedures including strategy and new product and service development and has successfully provided foundations for short and long-term innovative activities.

Another contribution relates to management practices and innovation management in particular. The analysis of corporate venturing dynamics at the organizational level reveals dualities, which may take the form of opportunities as well as of tensions. Entrepreneurial innovation appears as a multi-faceted phenomenon, which does not emerge and evolve according to pre-defined patterns. In this regard, organizational actors may take different positions at different points in time: it, therefore, becomes crucial for organizations to manage this duality of interactions through ways and means, which integrate customer orientation into service innovation processes as benefiting from complementary mechanisms of business venturing developments. This study also corroborates the views of Audretsch et al. (2013), Yarbrough et al. (2011), and Carayannis (2008) that this continuous strategic orientation to innovation and flexibility is characterized by pro-activeness as it allows firms to appreciate future risks and take the necessary actions to obviate competitors; check on global technological advancements (in this case by adopting, adapting and developing innovations for the local market); and meet customers’ needs (by developing service products that meet customer requirements). Here comes the ability of the company not to develop its strategy and count only on the benefits of the short-term goals, but also consider long-term planning as the tunnel to success and sustainability. In other words, “the ability of an organization to focus on both the short and the long term is one of the key critical enterprise success factors, and this balance can be achieved by relying upon and leveraging technological learning processes at multiple levels within the organization” (Carayannis, 1998, p. 699). To sum up, we see that service innovation requires the application of organization design and governance competencies that incorporate resources, dynamic capabilities, and entrepreneurship to develop such competitive advantages and explore new business opportunities so that firms may achieve organizational sustainability. Moreover, the emphasis on innovation, flexibility, and ambidexterity is a prerequisite for successful service innovation that meets customers’ demands in addition to organization design for innovation that act as an enabler of sustainability. Finally, the study has found that cross-organizational and cross-functional
collaborations are factors of success and facilitate the implementation of customer-driven service innovation.

Table 8.1 Summary of the results

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Findings that answer the research questions</th>
<th>Propositions</th>
<th>Findings that support propositions</th>
</tr>
</thead>
<tbody>
<tr>
<td>RQ1: Where, how and why should patients be involved in new service development?</td>
<td>Competition appears to influence the development of health services. Patients, however, seem not to be considered by the case hospitals as capable of contributing to the NSD process</td>
<td>P1: Strong competitiveness in the healthcare business sector is likely to induce more business openings. Thereby, further business growth will be generated in underdeveloped sectors of the healthcare service industry.</td>
<td>Intense competition, infrastructure, geographic location, speed, and quality of services, and cooperation with the insurance funds are the main factors that lead Healthcare companies to seek access to innovation and to business development.</td>
</tr>
<tr>
<td>RQ2: How do medical personnel perceive patient involvement in new service development?</td>
<td>Medical staff agreed that patients should increase their presence and participation in hospitals’ innovation activity. It appears, therefore, that they are positive towards patients’ involvement in the NSD process. In addition, ideas for development mainly come from the medical staff, therefore, their role in service development appear to be critical. Service providers should support patients, offering training and opportunities for preparation and debriefing. Hospitals should also collect and use information to reduce complaints, enhance customer satisfaction, and meet their needs. The case hospitals, however, do not use tools, processes, and methods that would allow them to involve patients in the development process.</td>
<td>P3: A number of new service opportunities will be created by implicating patients in the ideation process. P4: Customer-oriented services will be generated by involving mental health service recipients in service development process.</td>
<td>Customers are prepared to provide ideas for NSD, which will address unmet needs. The case organisations choose to build strong relationships with doctors and with customers. This also highlights medical staff's critical role in hospitals’ operation. In this case, the hospitals appear not to exploit customers in idea generation. Customers do not participate in NSD, but generally, the examined organisations are keen in introducing techniques and mechanisms for monitoring requests and incorporating customers to trigger innovation and develop offerings that meet the needs of patients.</td>
</tr>
<tr>
<td>RQ4: How and to what extent is corporate venturing developed by adopting service innovation initiatives?</td>
<td>Companies that adopt formal processes develop successful outcomes. Additionally, culture and organisational structure appear to be critical factors for the exploitation of business opportunities. The examined organisations, however, seem not to employ such strategies and processes for NSD, nor have a culture that promotes innovation. Therefore, the results show that they do not use service innovation in their corporate venturing activities.</td>
<td>P2: Original entrepreneurial opportunities addressed to healthcare organizations may be discovered by enriching business development processes with innovative services.</td>
<td>The case hospitals seek the extension, upgrading, and development through investments in services and business expansion. They also promote entrepreneurship to exploit opportunities and meet the needs of patients. In addition, they adopt corporate venturing strategies.</td>
</tr>
</tbody>
</table>
8.3.2 Applied contribution and implications for case hospitals

Although the findings of this study have proved that case hospitals follow unsophisticated and unofficial procedures during new offerings’ implementation, thriving, and profitable new services require well-planned and thoroughly examined procedures so that they are appropriately developed (Gremyr et al., 2014; Weber and Van der Laan, 2014). A service innovation process funds the bedrock for the development of new services and refers to the parallel and subsequent activities that must take place so that the service in question is accomplished (Fox et al., 2014; Bettencourt et al., 2013). The review of the literature has shown that this amplifies the possibility of success and results in high-quality service innovation for institutions that follow formal processes (Hidalgo and D’Alvano, 2014).

Official processes for new service development are often followed by firms as they ensure novel offerings’ success. These formal processes comprise stages, predetermined activities, and assessment points that allow inspection and analysis of ideas that may turn into profitable services (Hsieh and Hsieh, 2012). The studies by Autio et al. (2014), and Cambra – Fierro et al. (2011) claim that companies need to adopt an entrepreneurial behavior that will be sustained by the appropriate culture and organizational structure. Another study by Garrett and Neubaum (2013) enforces the aforementioned viewpoint by stating that firms should create the appropriate structure and form the culture within the organization that will boost entrepreneurship and innovation and motivate employees to take on the new business. Despite this, findings showed that the case health institutions have not promoted this type of actions. Many respondents stressed that there were breaches concerning staff participation in the decision-making process and their collaboration with the administration. In fact, most respondents consider that companies should take additional steps to let innovation prosper.
without limitations so as to upgrade the organization’s structures and achieve better results. It is obvious that most health firms have a lack of a specific plan and an appropriate process to run their innovative activities and this may inhibit the implementation of their development projects. As a result, they need to reflect on implementing strategic plans for the development of service innovation. It is obvious that a clear innovation strategy offers specific directives for dealing with strategic issues, such as selecting the suitable markets to enter and the skills to develop, and emphasizes the effort of the entire organization on a joint innovation objective (Bock et al., 2012; De Brentani et al., 2010). An important parameter on which health organizations should concentrate is their operations’ expansion in new markets and sectors, as well as the search for new business opportunities that will assist them in improving their competitive position. All this evidence answers the fourth research question, underlining that the examined hospitals do not take enough action so as to take advantage of service innovation in corporate venturing activities.

Findings show that some the case hospitals (i.e. Thermaikos, Galini) doubt patients’ and mental health service users’ competence to have a significant role in the process of new service development. It is claimed that they can only influence the improvement of hospitals’ residential offerings. This finding elucidates their role in the process, responding to the first research question. Additionally, it becomes obvious that no culture exists and no organization that focuses on their needs and implicates them into the service development procedure. Moreover, there is a complete absence of the constituents – such as flexibility for adjustment to customers’ needs, sufficient tools, procedures and methods of tracing and eliminating users’ complaints – that could generate motivation for development. Therefore, it has been observed by numerous studies that an organized effort by the company would have highly positive effects on patients. This argument is supported by the literature as several studies suggest that companies should make efforts and plans to speculate customers’ needs and fulfill those needs by developing particular services (e.g. Homburg et al., 2011; Tajeddini, 2010). Other studies also acknowledge that businesses that are focused on customer needs improve customer satisfaction and deliver better service quality (e.g. Grissemann et al., 2013; Witell et al., 2011). For this reason, healthcare institutions should address new approaches to attaining patient satisfaction, since these affect enormously the company’s overall performance (Ennis and Wykes, 2013; Bellou, 2010).
8.3.3 Limitations of the study

The present research has thoroughly examined prior literature relevant to the conceptual framework of the study; however, there exist some more papers that could assist in broadening the content of the analyzed topic. The limitless amount of experimental studies concerning service innovation and entrepreneurship led to the necessity of setting a limit on the subject-matter of the research so as to avoid analyzing other significant aspects and perspectives of the examined topic that require a separate study. Furthermore, more of the existing literature focuses on the context of technological innovation and, as a result, it was not simple to find literature about customer orientation and, mainly, about patient implication. Also, other research theories (i.e. market orientation, Healthcare policy, and legislation) could also be part of the conceptual framework to provide a higher level of awareness for both the development of customer-centered services and the utilization of business opportunities. Nevertheless, inquiries addressed by possibly informative supplementary secondary data were already answered adequately by the previous theoretical work gathered and included in the review. Since the healthcare industry is a significant context, there is a broad range of aspects to it, such as services’ provision, service users, suppliers, government regulations, and so forth. Several perspectives implicated in the research framework directed towards the broad scope of the literature review. However, an endeavor to emphasize and synthesize them has been made. Moreover, data for the Greek mental healthcare market had to be collected and delved into, but preceding studies and literature retrieval was challenging, and it has been unfeasible to retrieve several data. Data derived from other sources such as expert interviews served as a replacement and as a means of balance maintenance.

Limitations of the conceptual framework

The theoretical context that lays the foundations for the evolution and promotion of new offerings centered on the customer and for the exploitation of new business openings is somewhat limited. It comprises four main concepts, which are conceived in the study as the most significant in the process of evolving innovative and entrepreneurial skills. Some less essential notions that would have rendered the framework more intricate were not considered valuable enough to be included, such as cooperation between business units and
departments, knowledge sharing procedures, and skills, as well as marketing effectiveness. The study’s scope is limited, and some additional factors have been excluded from the framework, such as environmental, technological, social, legal that also affect a company’s innovative endeavor.

Limitations of research methods and techniques

The research methods applied to the two phases of the study have been limited as far as it concerns issues regarding sample size and frame, as it has been mentioned in Section 5.2.6. There existed a limited choice of samples since accurate data was required from top executives with high positions within the organization. Even though the number of qualitative samples was far from optimal, the high quality of the samples of chief executives from the case organization redeemed for this and contributed to the data validity.

By having taken into account all sections of the study, the main limitation has probably been the issue of purposeful and intended sampling, as it is not often practicable to apply the outcomes of such sampling to the overall population. For instance, a greater number of both public and private healthcare institutions could be implicated in this type of research to augment and enhance the amount of data, enriching results’ consistency and validity and offering a fertile ground for the application of the conclusions to all mental healthcare institutions. Furthermore, the participation of a larger sample of medical and nursing staff would possibly add to the consistency of findings, even though, in reality, most of the medical and nursing employees of the case mental healthcare organizations were involved in the research. Likewise, patients could also be part of the study; this would offer a specimen of their motivation and willingness to support service development activities. In this case, quantitative techniques would be appropriate for generalizing the outcomes to mental health services users. A large and diverse sample of mental health service users and mental health hospitals would have amplified the credibility and validity of the results, rendering feasible their application to other patients. Nevertheless, the advantages of a case study as described and elucidated in Section 5.1.4 regulates this limitation.
8.4 Extensions and recommendations for further study

The present study’s theoretical and conceptual frameworks have been established under a restricted scope. To further develop and enrich this study, we see other dimensions of customer-driven service innovation remain to be further explored as regards to the development of firm’s dynamic capabilities. This description of other possible sources of entrepreneurial innovation in intra-organizational dynamics represents a gap in the current academic literature and stands as an interesting opportunity for future research. Measurement issues linked to the intangible knowledge value emerging from business-customer interactions should be examined.

Initially, although the advantages of following customer-oriented techniques have been analyzed, the critical importance of maintaining a market orientation during the new service development process might have been overlooked. This notion applies principally to the healthcare industry, in which policy makers, suppliers, and internal customer service personnel usually play a significant role in service provision. What is more, studies should take into account the fact that entrepreneurial innovation configurations may vary according to the restructuring efforts of the organisations. This gap in innovation and entrepreneurship literature introduces the need to compare and contrast different types of configurations, aiming to enrich the understanding of the evolution of entrepreneurial innovation dynamics as well as the impact on the organisations’ customer orientation strategies. Consequently, future research should examine the mechanisms that affect customer relationships and the identification of actions aiming to manage these evolutions proactively. Furthermore, even though the topics of corporate venturing and customer orientation have been discussed in this study, the area concerning the connection and interaction between these two could use additional research. Other areas that may require more precise focusing include the ways stakeholders can affect new health service development, as well as the way and the extent to which customers benefit from the corporate venturing process. Another area that needs to be analyzed is the exploitation of entrepreneurial opportunities and patients’ implication public mental healthcare hospitals. Although this study broadens the horizons of our knowledge regarding the development of new services in the private healthcare industry, it
does not take into account the conditions and the forces that govern the public healthcare sector.

The author has also highlighted that few academic contributions have explored patient involvement in service innovation at the intra-organizational level. In this perspective, more research needs to be carried out on the dynamics of intra-firm service innovation. In particular, service innovation and entrepreneurship as a recent body of research still lacks a systematic identification and exploration of important factors influencing the phenomenon, such as interactional and organizational dimensions (organizational network positioning, the role of knowledge brokers, and so forth). This systematic identification would enable building the ground for solid theoretical foundations of antecedents and consequences of customer-oriented innovation within firms, especially those operating in the healthcare industry. This research initiates such efforts by contributing a new perspective of the outcomes of intra-organizational service innovation as regards the evolution of knowledge dynamics and firm value creation. With respect to future research directions, and from a managerial standpoint, subsequent studies could consider covering means to support innovation internally without causing a rise in the occurrence of tricky situations or knowledge hoarding behaviors among organizational actors. Moreover, as mentioned in the previous section (8.3), future studies should apply quantitative research to allow generalization of findings. The conceptual framework developed in this research should also be applied to other industries or fields to assess its applicability and viability.
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APPENDICES

APPENDIX 1

Appendix 1.1  Semi-structured interview questions for senior executives for research phase 1 (English Version)

Innovation: Activity, factors, and business culture

1. What are the internal factors that predispose the organisation to seek access to innovation?

2. How and to what extent do external factors such as legislation, social and economic, condition or stimulate favourable attitudes towards innovation?

3. Are adequate tools and processes used to generate opportunities for product development?

4. Does the organisation do enough to create:
   a. A culture where continuous improvement is regarded as a norm?
   b. Incentives for staff to identify and act on opportunities for improvement?

5. How adequately or appropriately are the requirements of customers taken into account in organisation’s innovation strategy?

6. Do you believe that customers/patients can contribute something extra to the service innovation process?

7. What do you think is the role of the top executives/medical staff in promoting the internal innovation process?

8. Do you believe that the stimulus of growth could help you become more innovative, developing new services and approaching new markets and why?

9. Do you believe that the organisation and the structure of the hospital help you to implement innovative actions? If so, how does this happening?

New Service Development: Process, service improvement and evolution, and coordination

10. Did the organisation introduce any new or significantly improved service in mental health sector?

11. How many new services did you introduce last year?
12. How and to what extent has your service products changed during the past 2 years?
13. Does the organisation have a plan for the extension and evolution of its services?
14. Where did the concept of developing new services come from? (existing customers, new customers, market research, always part of the plan?)
15. How would you evaluate the coordination among people and departments throughout the new service development process?

**Corporate Entrepreneurship: Business model, venturing activities, entrepreneurial opportunities**

16. Will you please describe the venturing and entrepreneurial activity in the organisation?
17. What are the hospital’s venturing objectives?
18. How are entrepreneurial opportunities identified, evaluated and selected by the organisation?
19. How does the organisation encourage and support entrepreneurial activity? How does it recognise and reward innovative efforts?

**Customer Orientation: Market assessment, customer relationships and involvement, service customisation, customer satisfaction**

20. What preliminary market assessments occurred before any investment was undertaken? (market research, market segmentation)
21. Is there a clear idea of the type of information to be obtained through market assessment?
22. How much time and effort is spent in conducting interdepartmental meetings to discuss market trends and developments?
23. What type of relationship does the organisation have with its customers?
24. Is there an adequate process to track and respond to customer queries and complaints? If so, does management get an up to date of the status of complaints?
25. Is there a robust mechanism to integrate the views of customers into the service planning process?
26. How much room is there for customisation and judgement on the part of service provider?

27. Please determine the ways by which the hospital can increase customer involvement in its innovative activity.

28. Are there measures of customer satisfaction that you use to improve your services?

Appendix 1.2 Semi-structured interview questions for senior executives for research phase 1 (Greek Version)

Καινοτομία

1. Ποιοι είναι οι εσωτερικοί παράγοντες που παρακινούν τον οργανισμό να είναι καινοτόμος;

2. Πώς και σε ποιο βαθμό οι εξωγενείς παράγοντες παράγοντες όπως κοινωνικοί και οικονομικοί, νομοθεσία, καθορίζουν τη στάση του οργανισμού προς την καινοτομία;

3. Χρησιμοποιείτε κατάλληλα εργαλεία και διαδικασίες με σκοπό την ανάπτυξη/βελτίωση υπηρεσιών;

4. Πιστεύετε πως προσπαθεί ο οργανισμός να δημιουργήσει:
   a. μια νοοτροπία όπου η συνεχής βελτίωση θεωρείται ως πρότυπο και με ποιο τρόπο;
   b. κίνητρα για το προσωπικό ώστε να εντοπίσει και να ενεργήσει σχετικά με τις ευκαιρίες για βελτίωση;

5. Κατά πόσο λαμβάνονται υπόψη οι απαιτήσεις των πελατών στη στρατηγική καινοτομίας του οργανισμού;

6. Πιστεύετε ότι οι πελάτες-ασθενείς μπορούν να συνεισφέρουν επιπλέον στη διαδικασία ανάπτυξης υπηρεσιών;

7. Ποιος πιστεύετε ότι είναι ο ρόλος των κορυφαίων στελεχών στην προώθηση της εσωτερικής διαδικασίας της καινοτομίας;

8. Πιστεύετε ότι το κίνητρο της ανάπτυξης θα μπορούσε να σας βοηθήσει να γίνετε περισσότερο καινοτόμοι, αναπτύσσοντας νέες υπηρεσίες και προσεγγίζοντας νέες αγορές και γιατί;

9. Πιστεύετε ότι η οργάνωση και οι δομές του οργανισμού βοηθούν στην υλοποίηση καινοτόμων ενεργειών και με ποιο τρόπο;
Ανάπτυξη Νέων Υπηρεσιών

10. Έχει εισάγει ο οργανισμός οποιαδήποτε νέα ή βελτιωμένη υπηρεσία στην αγορά ψυχικής υγείας;
11. Πόσες νέες υπηρεσίες έχετε εισάγει τον τελευταίο χρόνο;
12. Πώς και σε ποιο βαθμό οι υπηρεσίες σας έχουν αλλάξει τα τελευταία 2 χρόνια;
13. Έχει σχέδιο ο οργανισμός για την επέκταση και εξέλιξη των υπηρεσιών της;
14. Από που προέρχονται οι ιδέες για την ανάπτυξη νέων υπηρεσιών; (Υπάρχοντες πελάτες, νέοι πελάτες, έρευνα αγοράς, πάντα μέρος του σχεδίου);
15. Πώς θα αξιολογούσατε τη συντονισμό μεταξύ των ανθρώπων και των τμημάτων των κλινικών καθ’ όλη τη διάδοση ανάπτυξης νέων υπηρεσιών;

Εταιρική Επιχειρηματικότητα

16. Μπορείτε να περιγράψετε το επιχειρηματικό μοντέλο του οργανισμού;
17. Ποιοι είναι οι επιχειρηματικοί στόχοι του οργανισμού;
18. Πώς εντοπίζονται, αξιολογούνται και επιλέγονται οι επιχειρηματικές ευκαιρίες από τον οργανισμό;
19. Πώς ο οργανισμός ενθαρρύνει και στηρίζει την επιχειρηματική δραστηριότητα; Πώς αναγνωρίζει και επιβραβεύει τις καινοτόμες προσπάθειες;

Εστίαση στον Πελάτη – Ασθενή

20. Τι είδους εκτιμήσεις της αγοράς σημειώνονται πριν από την πραγματοποίηση κάθε επένδυσης;
21. Υπάρχει σαφή ιδέα για το είδος των πληροφοριών που πρέπει να ληφθούν μέσα από την αξιολόγηση της αγοράς;
22. Διεξάγονται διατμηματικές συνεδριάσεις για να συζητηθούν οι εξελίξεις και οι τάσεις της αγοράς;
23. Τι είδους σχέση έχει ο οργανισμός με τους πελάτες του και πως διατηρείται η σχέση αυτή;
24. Υπάρχει η κατάλληλη διαδικασία για να παρακολουθείτε και να ανταποκρίνεστε στις ερωτήσεις των πελατών και τις καταγγελίες τους;
25. Υπάρχει ένας μηχανισμός που να ενσωματώνει τις απόψεις των πελατών στη διαδικασία του σχεδιασμού νέων υπηρεσιών;
26. Υπάρχει ευελιξία για παραμετροποίηση των παρεχόμενων υπηρεσιών και κρίση από την πλευρά του οργανισμού;
27. Παρακαλώ αναφέρετε τον τρόπο με τον οποίο ο οργανισμός δύναται να διευρύνει τη συμμετοχή των πελατών στις καινοτόμες δραστηριότητές της.
28. Χρησιμοποιείτε εργαλεία μέτρησης της ικανοποίησης των πελατών για να βελτιώσετε τις υπηρεσίες σας; Αν ναι, ποια είναι αυτά;

**APPENDIX 2**

Appendix 2.1  **Semi-structured interview questions for medical personnel for research phase 2 (English Version)**

1. Are adequate tools and processes used to generate opportunities for product development?
2. Does the organisation do enough to create:
   a. A culture where continuous improvement is regarded as a norm?
   b. Incentives for staff to identify and act on opportunities for improvement?
3. What do you think is the role of the medical staff in promoting the internal innovation process?
4. Did the organisation introduce any new or significantly improved service within the past 2 years?
5. How many new services did the hospital introduce last year?
6. How and to what extent have your service products changed during the past 2 years?
7. How would you evaluate the coordination among people and departments throughout the new service development process?
8. Is there an adequate process to track and respond to customer queries and complaints? If so, does medical staff get an up to date of the status of complaints?
9. How much room is there for customisation and judgement on the part of service provider?
10. Please determine how firm can increase customer involvement in its innovative activity.
11. Are there measures of customer satisfaction that you use to improve your services?
Appendix 2.2  Semi-structured interview questions for medical personnel for research phase 2 (Greek Version)

1. Χρησιμοποιούνται κατάλληλα εργαλεία και διαδικασίες με σκοπό την ανάπτυξη/βελτίωση υπηρεσιών;
2. Πιστεύετε πως προσπαθεί η κλινική να δημιουργήσει:
   a. μια νοσοτροπία όπου η συνεχής βελτίωση των παρεχόμενων υπηρεσιών θεωρείται ως πρότυπο;
   b. κίνητρα για το προσωπικό ώστε να εντοπίσει και να ενεργήσει σχετικά με τις ευκαιρίες για βελτίωση;
3. Ποιος πιστεύετε ότι είναι ο ρόλος του επιστημονικού προσωπικού στην προώθηση της εσωτερικής διαδικασίας της καινοτομίας;
4. Έχει εισάγει η κλινική οποιαδήποτε νέα ή βελτιωμένη υπηρεσία στην αγορά ψυχικής υγείας τα τελευταία 2 χρόνια;
5. Πόσες νέες υπηρεσίες έχετε εισάγει τον τελευταίο χρόνο;
6. Πώς και σε ποιο βαθμό οι υπηρεσίες σας έχουν αλλάξει τα τελευταία 2 χρόνια;
7. Πώς θα αξιολογούσατε την συντονισμού μεταξύ των ανθρώπων και των τμημάτων της κλινικής καθ’ όλη τη διαδικασία, ανάπτυξης νέων υπηρεσιών;
8. Υπάρχει μια επίσημη μέθοδος με την οποία οι καταγγελίες, οι ερωτήσεις και οι χαμηλές επιδόσεις τροφοδοτούν πρωτοβουλίες για την ανάπτυξη νέων υπηρεσιών;
9. Υπάρχει ευελιξία για παραμετροποίηση και κρίση από την πλευρά της κλινικής;
10. Παρακαλώ αναφέρετε τον τρόπο με τον οποίο η κλινική δύναται να διευρύνει τη συμμετοχή των ασθενών στις καινοτόμες δραστηριότητές της;
11. Χρησιμοποιείτε εργαλεία μέτρησης της ικανοποίησης των ασθενών για να βελτιώσετε τις υπηρεσίες σας; Αν ναι, ποια είναι αυτά;
APPENDIX 3

Appendix 3.1 Letter from the Ethics Committee

University of Portsmouth Staff Mail - Ethical Review application ref. E303 [resubmis...  Page 1 of 1

Stavros Sindakis <stavros.sindakis@port.ac.uk>

Ethical Review application ref. E303 [resubmission] : Stavros Sindakis

Sharman Rogers <sharman.rogers@port.ac.uk> 14 November 2014 at 11:25
To: Stavros Sindakis <stavros.sindakis@port.ac.uk>
Cc: Paul Trott <paul.trott@port.ac.uk>, PBS-Ethics <pbs.ethics-group@port.ac.uk>

Dear Stavros,

Ethics Committee has given a favourable ethical opinion to Ethical Review application ref. E303 and thanks you for your efforts.

Best wishes

Sharman Rogers

University of Portsmouth
Business Services & Research Office
Portsmouth Business School
Portland Building, Portland Street
Portsmouth, Hampshire PO1 3AA UK
T: +44 (0)23 9284 4202

What we offer business:
http://www.port.ac.uk/portsmouth-business-school/find-out-more/
Services for Business
Research
Talent Development
Events and Open Evenings

The Value-Added Board - - what you need to know to add value in the Boardroom

https://mail.google.com/mail/u/1/?ui=2&ik=2f5582f7521&view=pt&search=inbox&m...  23/03/2015

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Appendix 3.2  UPR16 Form

FORM UPR16
Research Ethics Review Checklist

Please complete and return the form to Research Section, Quality Management Division,
Academic Registry, University House, with your thesis, prior to examination.

<table>
<thead>
<tr>
<th>Postgraduate Research Student (PGRS) Information</th>
<th>Student ID: 379047</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candidate Name: Stavros Sindakis</td>
<td></td>
</tr>
<tr>
<td>Department: Strategy, Enterprise and Innovation</td>
<td></td>
</tr>
<tr>
<td>First Supervisor: Professor Paul Trott</td>
<td></td>
</tr>
<tr>
<td>Start Date: (or progression date for Prof Doc students)</td>
<td>02/2014</td>
</tr>
</tbody>
</table>

Study Mode and Route:
- [ ] Part-time
- [ ] Full-time
- [ ] MPhil
- [ ] MD
- [ ] PhD
- [ ] Integrated Doctorate (New Route)
- [ ] Prof Doc (FD)

Title of Thesis: Corporate venturing dynamics and patient involvement in service innovation: An exploratory study of private sector hospitals in Northern Greece

Thesis Word Count: 52478 (excluding ancillary data)

If you are unsure about any of the following, please contact the local representative on your Faculty Ethics Committee for advice. Please note that it is your responsibility to follow the University’s Ethics Policy and any relevant University, academic or professional guidelines in the conduct of your study. Although the Ethics Committee may have given your study a favourable opinion, the final responsibility for the ethical conduct of this work lies with the researcher(s).

UKRIO Finished Research Checklist:
(if you would like to know more about the checklist, please see your Faculty or Departmental Ethics Committee rep or see the online version of the full checklist at: http://www.ukrio.org/what-we-do/code-of-practice-for-research/)

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<tbody>
<tr>
<td>a) Have all of your research and findings been reported accurately, honestly and within a reasonable time frame?</td>
<td>YES</td>
</tr>
<tr>
<td>b) Have all contributions to knowledge been acknowledged?</td>
<td>YES</td>
</tr>
<tr>
<td>c) Have you complied with all agreements relating to intellectual property, publication and authorship?</td>
<td>YES</td>
</tr>
<tr>
<td>d) Has your research data been retained in a secure and accessible form and will it remain so for the required duration?</td>
<td>YES</td>
</tr>
<tr>
<td>e) Does your research comply with all legal, ethical, and contractual requirements?</td>
<td>YES</td>
</tr>
</tbody>
</table>

*Delete as appropriate

UPR 16 (2013) – November 2013
**Candidate Statement:**

I have considered the ethical dimensions of the above named research project, and have successfully obtained the necessary ethical approval(s)

<table>
<thead>
<tr>
<th>Ethical review number(s) from Faculty Ethics Committee (or from NRES/SCREC):</th>
</tr>
</thead>
</table>

| Signed: | Date: 23/03/2015 |
| Student | |

If you have not submitted your work for ethical review, and/or you have answered ‘No’ to one or more of questions a) to e), please explain why this is so:

| Signed: | Date: |
| Student | |

UPR 16 (2013) – November 2013