Clinical leadership in UK health care: exploring a marketing perspective

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Abstract

Purpose – The purpose of this paper is to explore the application of marketing in health care, and in particular to assess its relevance to clinical leadership in the UK NHS.

Design/methodology/approach – The paper discusses a marketing perspective using literature and policy material.

Findings – The paper suggests that a marketing perspective is relevant in the UK NHS. Health service reforms have created a market in which choice and competition are levers for improving performance. Central to this is the notion of patient choice. Marketing is a way of exploring these issues. The paper suggests that there may be resistance to ideas originating from the private sector, and this needs to be overcome.

Practical implications – Marketing offers a framework and a set of techniques with which to improve organisational performance and ensure a focus on quality in meeting the needs of the patient. The new payment-by-results funding system ensures that money follows patients. Providers will need to focus on quality to attract patients and track resulting funding streams.

Originality/value – The paper demonstrates that private sector methods and techniques are relevant in the public sector, although one must take into account differing contexts.

Keywords National Health Service, Relationship marketing, Marketing mix, Clinical medicine, Leadership, United Kingdom

Introduction

Clinical leadership is considered by policy makers to be an essential prerequisite in the current health service reforms in the UK. There has been renewed emphasis on this in recent policy statements (Department of Health, 2007c).

Clinical leadership is essentially “about effective delivery of health care at the front line” (Millward and Bryan, 2005, p. xiii), and may be exercised by any clinical professional, not necessarily those in managerial positions. It is important because of the role in planning service delivery and in identifying how to meet the requirements of patients who are increasingly seen as the “customers” in a healthcare market. Clinical leadership is fundamentally about transforming the service provided in this market in such a way that it meets the needs of patients:

The essence of clinical leadership is to motivate, to inspire, to promote the values of the NHS, to empower and to create a consistent focus on the needs of the patients being served (Department of Health, 2007b, p. 49).

The UK healthcare market relies, increasingly, on the mechanism of “patient choice” to ensure a focus on the requirements of patients and to improve the performance of healthcare providers. The question of choice provides a link to marketing, given the centrality of choice in the latter:
marketing is about thinking intelligently and appropriately about choice, understanding how people wish to choose and helping them to make choices (Scrivens, 2006b).

For these reasons, there has been renewed interest in the NHS in adopting a marketing perspective. This paper will explore the marketing perspective and its relevance to clinical leadership and the implementation of current health reforms in the UK. The premise is that marketing is relevant to health care, not least because of its focus on enhancing the quality of service delivery by ensuring greater responsiveness to patients.

It may be noted that the application of marketing to health care has been the subject of some scepticism from various quarters, not least health care staff themselves:

- marketing is more about commercial as opposed to social or care objectives;
- the competition upon which it is based will bring about the pursuit of profit and not quality of care;
- health care is different from other services/products, and is less amenable to the techniques and approaches of marketing;
- it is, to a large extent, an intangible service;
- it is a unique service because of the individual freedom of clinicians;
- it operates with unpredictable demand; and
- it is ambiguous in terms of being unable to offer a precise definition of the “customer” (partly based on Scrivens, 2006a, b).

However, the renewed emphasis on patient choice, contestability amongst providers, and the creation of a new “internal market” is beginning to change this scepticism about the contribution of marketing to the NHS (Scrivens, 2006b). It can be noted at this point that “new internal market” means a return to one created in 1990 by the last UK government. The latter created competition for patients between providers of health care within the NHS. However, the market has now been extended to include a much wider range of providers, both from the NHS and the independent sector.

### Policy context

The policy context in the NHS has shifted away from collaboration towards competition, choice and patient empowerment, although, paradoxically, both collaboration and competition continue to co-exist. Competition is ultimately about providers competing for patients, supported by a financial system in which money follows patients. This has been reinforced by major policy reforms such as the NHS Plan (Department of Health, 2000), the white paper, *Our Health, Our Care, Our Say* (Department of Health, 2006), and *Our NHS, Our Future* (Department of Health, 2007b).

The most recent advice reiterates emphasis on choice as a key mechanism and says this should be “embedded within the full spectrum of NHS funded care” (Department of Health, 2007b, p. 6), and similar guidance states that healthcare organisations should offer “individuals greater choice over the services and treatments available to them” (Department of Health, 2007a, p. 18).

The major themes in these reforms are wide-ranging, based on this central requirement to bring about greater choice and competition within a health care market:

- the move to free choice for patients;
- payment by results and money following patients;
Together, these reforms have had the effect of reintroducing competition for patients amongst a diverse range of provider units. A major part of the present government’s reform programme is the “marketisation” of public services, be they health care, education, or other public services.

The buyer/supplier healthcare market

Primary care commissioners (i.e. the “buyers”) are charged with the task of rolling out patient choice and referral at practice level: all patients who require a hospital appointment are to be offered, within the general practitioner surgery, a choice from a range of alternative providers (the “suppliers”).

The introduction of choice means there will be competition for patients, with different providers being forced to compete on grounds of quality, not price (the latter being fixed by national tariff). The implementation of choice is meant to provide an incentive system for providers to become more responsive and provide a better service to patients. The latter is seen as an important driver of quality improvement and part of the aim to provide a more personalised service. It has been pointed out that there is need for improvement:

...patients sometimes feel treated as numbers, are made to wait too long, do not have their condition or treatment explained sufficiently, feel lost in the system, receive poor customer service, are denied choice and experience basic lapses in care (Department of Health, 2007b, p. 23).

In a sense, it offers both a “carrot and stick” approach. On the negative side, there is “a credible threat for providers who do not provide care that is accessible and responds to patient requirements” (Ham, 2007, p. 3). On the positive side, providers who attract patients, for example, by quality of service, will be paid for work done, and will be incentivised to do more work and gain more income, thus rewarding performance (Boyle, 2005).

Healthcare organisations operating in this market will be required to gather market intelligence on a range of issues relevant to the above:

- the structure of their market;
- the nature of “customer” demand;
- market segmentation;
- the relative strengths and weaknesses of competitors; and
- a more precise definition of “customer” needs.
Commissioners – primary care trusts (PCTs) and practice-based commissioners – will have to develop a more strategic, proactive approach to manage these issues. As a buyer or commissioner of services, PCTs will be involved strategically in shaping and regulating the health care market. For example, commissioners might be involved in making “arrangements to ease market entry for some providers, manage the exit of others, and assure transparent rules for the local market” (Smith et al., 2006, p. 1).

Commissioners will also need to address differing expectations, going beyond the emphasis on identifying “need” to the consideration of “demand” from the local health market (Smith et al., 2006).

Clinical leadership
There is continuing interest in the contribution of clinical leadership to the above. It is seen as central to the promotion of the core values of the NHS, and to providing a “focus on the needs of patients being served” (Department of Health, 2007b, p. 49).

A central leadership role will be played by general practitioners (GPs) and other primary care professionals who are involved in implementing the reforms, and particularly those involved in commissioning roles. This applies generally to all GPs involved in practice-based commissioning but, in particular, to GPs involved in the new governance arrangements within primary care trusts (PCTs).

The DOH has provided guidance following a DOH-sponsored public consultation with clinicians and managers about the role of the Professional Executive Committee (PEC). This puts emphasis on the need to develop clinical leadership (Department of Health, 2007c, p. 3).

Clinical leadership will be operating in an increasingly turbulent and uncertain market environment. Clinical leaders will need skills and knowledge to enable them to identify and analyse this environment using appropriate tools and techniques. It is argued that clinical leaders will need to focus on the development of specific skills and marketing knowledge, including influencing skills, relationship building skills, interpersonal skills, leadership skills, diagnostic and analytical skills, and knowledge from within the marketing paradigm.

Marketing as a subject discipline is now considered relevant to health care, and therefore to clinical leaders. As pointed out: “social marketing and traditional market research are now being considered to be important techniques to be employed alongside [other healthcare techniques]” (Smith et al., 2006, p. 17).

The link between quality, marketing and health care
Given this new health care environment of competition and patient choice, an important factor is how best to compete in the new market place. As noted above, the government has fixed the price for services by national tariff so that price of service will not be the basis for patient choice and competition. Bramley-Harker and Lewis (2005, p. 7) suggest that:

… since price will not form part of this purchasing decision, patient choices will reflect the dimensions of quality that patients find to be important. These could be clinical quality, timeliness of treatment or possibly other “patient experience” factors.

Therefore, the expectation is that competition between providers will be about quality and standard of care – not price – and that this will enable patients to drive improvements in the quality of care.
The ability of providers to attract and retain patients could be dependent upon the extent to which they are able to demonstrate quality, but this means that quality itself must be clearly defined. Quality is subjective and difficult to define and may be approached from different perspectives. For example, it has been said that quality may be defined using three different but inter-related ways:

1. definitions based on the dimensions of quality;
2. definitions concerning the process of bringing about quality and the perceptions of patients; and
3. consumer-led definitions (Gaster, 1995, p. 34).

Some well-known dimensions of quality are listed below; these may be important in a competitive market:

- clinical effectiveness;
- access;
- equity;
- efficiency;
- acceptability;
- meeting “customer” needs; and
- “customer” satisfaction (adapted from Maxwell, 1984).

Quality in health care, therefore, is important in the new context of competition and patient choice but it must be clearly specified by commissioners and must take account of these different perspectives, not least the views of patients themselves. It must take account of the extent to which patient perceptions are being addressed and their expectations met, although it is clearly necessary to incorporate dimensions that reflect the importance of clinical effectiveness, safety, and efficacy.

In marketing terms, the requirement is to translate these quality concepts or dimensions into a competitive advantage to become “a unique range of selling points” (cited in MacIntosh, 2007, p. 4). As one Trust pointed out:

... we believe we have a range of services that will distinguish us from other providers. We believe that patients who come to us experience a quality of care they won’t get in other places (MacIntosh, 2007, p. 14).

The “brand” of the provider may become increasingly important in the competitive environment. The brand has a clear link with quality: “the brand is built around the [NHS organisation’s] reputation for efficient service, consistent offering and quality” (Simoes and Dibb, 2001, p. 217). A brand is a way of distinguishing one provider from another; it has been described as a recognisable corporate identity, and can be perceived in terms of:

... ethos, aims and values and presents a sense of individuality that can help to differentiate the organisation within its competitive environment (Balmer, cited in McDonald et al., 2001, p. 336).

The above issues are a major part of marketing as a distinct subject discipline (Rowley, 1997). It means that clinical leaders, whether in provider or buyer organisations, are likely to find themselves under pressure to adopt a more patient-focused approach and embrace the marketing concept as a fundamental part of the managerial process.
The next section will briefly review two different, but not necessarily mutually exclusive, perspectives on marketing as a subject discipline.

**Perspectives on marketing as a subject discipline**

The academic subject of marketing, like management, is dominated by US academics and writers (Saunders and Lee, 2005). This means that one has to be wary about the transfer into the UK public sector of a discipline grounded in a very different culture and context. The other point to note is that, unlike other academic disciplines, marketing is still perceived as an embryonic discipline that needs to establish its own paradigm; it derives most of its underpinning knowledge from traditional social science disciplines such as economics or psychology (Littler and Tynan, 2005).

**The marketing mix**

The development of the main tradition in marketing dates back to around the 1960s with the establishment of the so called “marketing mix” – the four Ps of product, price, place, and promotion.

This approach has tended to dominate marketing ever since “the four Ps of the marketing mix became an indisputable paradigm” (Grönroos, 1997, p. 322), although in recent years it is has been subject to increasing challenge and new approaches have emerged, for example, industrial marketing, services marketing and approaches based on customer relationships (Grönroos, 1997).

The key dimensions are:

1. to consider the nature of the product or service to be provided;
2. the place or setting for its delivery; the price of the product or service; and
3. the promotion of the service.

These can be used to conduct a “diagnostic analysis” of an organisation:

1. The product or service can be reviewed in terms of:
   - product/service attributes associated with core services;
   - service benefits; and
   - support services provided.

2. The promotion mix addresses issues relating to the image of the service conveyed.

3. The place involves assessment of:
   - location;
   - access; and
   - ambience.

4. The price (fixed in health care) or costs to be considered from the perspective of both provider and patient (based on Gilligan and Lowe, 1995, pp. 126-43; Scrivens, 2006a).

Apart from price, these dimensions are said to be “controllable” and therefore adjustable in the light of market changes. This enables decisions to be made about how to respond for example, in relation to a target market (Scrivens, 2006a). In health care, these dimensions can be translated into:
Within the same paradigm the marketing mix has been extended to include a wider range of variables. There is a version of the marketing mix with seven P’s, with the addition of people, process management and physical evidence (Gilligan and Lowe, 1995). Using this framework, it is possible to conduct a more detailed analysis informing strategic decision-making. For example, it opens up the possibility of exploring the “patient journey” and implications for quality (process mix), and the importance of the staff contribution to internal/external marketing (people mix).

**Relationship marketing**

Relationship marketing refers to all marketing activities directed toward establishing, developing and maintaining successful relational exchanges (Morgan and Hunt, 1994) or:

... relationship marketing is maintaining and enhancing the relationship which an organisation has with its customers (Hatton and Mathews, 1996).

In the private sector, relationship marketing is focused on meeting customer needs or customer service as the basis for sustaining long-term relationships with customers.

One problem with this in the health service is being able to define the “customer” before engaging in relationship building. Another is the possibility there might be more than one “customer”.

A relationship marketing perspective points to the need to develop relationships or partnerships across multiple constituencies. Clinical leaders have developed expertise in managing clinical networks which may be transferable to building and sustaining relationships across these multiple constituencies.

At this level, there is a need to ensure that different parts of the health care system work together to produce mutually beneficial outcomes. This may be achieved by establishing relationships that transcend organisational or institutional boundaries. It has been argued that this relationship-building role is central to clinical leadership:

... the role of the clinical leader as a facilitator of the process of care delivery at the front line can be conceptualised as one of managing relationships (Millward and Bryan, 2005, p. xix).

Relationship marketing has been relevant, particularly since the reforms of 1997, when there was a shift of emphasis to collaboration between those commissioning and those providing health care services. It remains of interest in the more recent reforms, not least because of:

- its potential as a way of dealing with the uncertainty within dynamic, competitive environments; and
- the continuing importance of partnership working for example, between communities and their commissioners, PCTs and practice-based commissioners, and local government and third sector (Department of Health, 2007a, p. 11).

Relationship marketing has an emphasis on both attracting new patients and retaining existing patients by ensuring a focus on perceived quality and value. Quality is at the core of this process as there is an “emphasis on quality as a major part of customer or user retention” (Conway and Willcocks, 2000, p. 10).
Key quality concepts in relationship marketing approaches are “trust” and “promise” (Grönroos, 1997, p. 327). These are ways of establishing and maintaining longer-term relationships with your patients. Thus it is argued that:

... fulfilling promises that have been given is equally important as a means of achieving customer satisfaction, retention of the customer base, and long term profitability (Grönroos, 1997, p. 327).

In the NHS context, such promises may be encapsulated in terms of standards, protocols, and commissioning agreements but they are important for the same reasons as above. The concept of trust is based on the confidence of the patient in the services of the provider and this in turn may be based on “the expertise, reliability or intentionality” of the provider (Grönroos, 1997, p. 327). As noted earlier, these are dimensions of quality.

Relationship marketing is an important way of focusing on the dynamic of relationships between those providing services and those consuming services. It emphasises the importance of sustaining this relationship through attention to quality and to behavioural aspects of the relationship.

Implementation issues
The basis for a degree of cynicism about marketing and its relevance to health care was indicated earlier in this paper. There is the possibility that marketing may be met with some resistance, not least from clinical leaders themselves. This is partly due to the perception that health care is different from the private sector and that the services provided are not amenable to marketing concepts, techniques, and theory. Clinical leaders may need to be convinced about the value of adopting a marketing approach originating from the private sector.

It is important, therefore, to present marketing as clinically relevant and offering insight into improving clinical services and providing benefits for patients. This is one reason why the phrase “social marketing” is used, to distinguish it from marketing in the private sector.

In other words, it is important to avoid the risk of alienating clinical leaders who might see it as another managerial “fad” or panacea for the problems of the NHS. It has to be adopted critically and selectively and not merely seen as an “off the shelf” quick-fix solution.

Another risk is that marketing may have the effect of over-simplifying what is a highly complex health care business. The nature of the product or service, the customer, and its delivery are more complicated in the health care industry. Ultimately, it needs to be compatible with evidence-based approaches utilised within health care and particularly by clinicians and clinical leaders.

These difficulties may be overcome by ensuring that the marketing approach is embedded within culturally specific training and development programmes in the NHS. It may become part of training provided at post-qualification stage for all clinicians – doctors, nurses and therapists – who intend to become clinical leaders in the future.

These initiatives are important in terms of ensuring that marketing is accepted as an approach relevant to health care. They are important as ways of dealing with possible resistance to the idea of marketing as a viable approach in health care from clinical leaders themselves.
Conclusion
This paper has suggested that marketing may be of use to clinical leaders in different parts of the NHS. Clinical leadership may utilise the techniques and concepts of marketing in addressing the complexity of health care within an analytical framework aimed at improving organisational performance and effectiveness.

Marketing, with due recognition of its limitations and private sector origins, may be of value when applied to the health service context. It enables a focus on core aspects of organisational performance:

- the centrality of quality and standards in building for success;
- understanding the dynamic of the “customer” and “supplier” relationship;
- developing relationships with different stakeholders;
- identifying or specifying the attributes of core services;
- the importance of user involvement in the health service;
- the need to embrace a market philosophy and customer orientation;
- developing market-led strategies and applying the marketing mix; and
- analysing the nature of the health care market.

A marketing perspective may offer clinical leaders in provider or buyer organisations a way to explore these issues in more detail. It is clear from recent policy statements that the new market environment in health care is likely to remain at least for some considerable time, or until it is decided that other mechanisms are needed to improve organisational performance in the NHS.

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