Integrating Healthcare in Greater Manchester: A Strategic or Tactical Focus?

1. Introduction: Managing in the UK National Health Service

In the UK, the National Health Service, employs approximately 1.3 million people (representing almost 1 in 23 of the working population in the country), and comprising employees across a wide spectrum and a myriad of disciplines. The sheer scale and complexity of the service has left it open to question about its efficiency and to what extent central control can effectively address more local or regional needs. Simultaneously, it has been recognised that no longer can health services work alone which is driving a shift towards the integration of health with social care services. Together these are driving a new direction for service provision within the sector.

An issue regarding Healthcare provision, is the fact that it is more likely to be seen as a tactical issue rather than a strategic one. Indeed, a good deal of the literature on not-for-profit marketing tends to reflect this view (Stevens et al, 2013). It has been proposed that a major cause of this tactical emphasis is the existence of the division between Resource Attraction and Resource Allocation (Shapiro,1973; Birks and Southan 1991). Not-for-profit organisations generally have two different types of constituency or customer: the beneficiaries of the service and the service provider (the resource allocator). These separate constituents have differing needs. Resources are generated from a contributor market and then reallocated to a separate beneficiary market, and because 'consumers' do not always pay directly for the service, there is pressure for fund attraction. The allocation of these funds to the beneficiaries tends to be undertaken by people or departments not involved in such acquisition or typically there is a marketing function that sees its role as confined to communication which tends to be of a tactical, short-term nature. This allocation/attraction split exists creating a complicated management model for healthcare decision makers. One possibility is to utilise a relationship marketing perspective which aims to develop relationships not just with end users but also with other stakeholders such as employees, funders etc. The aim of this paper, therefore, is to develop a conceptual model which can be used to assess the extent to which a relationship marketing perspective can help institutions develop more of a strategic focus and thus become more successful.

2. Relationship Marketing

A broad view of the markets with which an organisation interacts is important. This is particularly pertinent in the health and social care sector where there was focus on didactic systems which have been replaced by complex service networks (McColl-Kennedy et al, 2012), often referred to as eco-systems (Frow et al., 2014; Vargo and Lusch, 2011). The World Health Organisation defines healthcare as including all actors, institutions and resources used to improve health (Bengoa and Kawar, 2006; Evans et al., 2001) and contemporary commissioning processes are seeing a widening of networks to include a plethora of actors and agencies involved, both internal and external to the focal organisation (Sweeney et al., 2015; Pinho et al., 2014; Lusch and Webster, 2011). Therefore, in addition to customer markets, there is the development and enhancement of

more enduring relationships with supplier, recruitment, referral, influence and internal markets (Christopher et al, 2013)**.** The extent to which the development of ongoing relationships represents a desirable strategy depends on the degree of turbulence in the market environment. The imperatives of an ageing population, advancing technology and budgetary constraints are creating increasing pressures on healthcare organisations to review and radically rethink approaches to service design. Given the above, a more strategic approach involving relationship marketing would appear worthy of consideration. By developing relationships with a variety of customer groupings such as employees, employers and regulators in addition to funders and end users, the gap between resource attraction and resource allocation could be bridged. In order to do this successfully, a healthcare organisation would have to develop a more strategic focus philosophically and structurally.

3. A Conceptual Model

Within the Healthcare context, the patient as a customer is a core element of a healthcare experience but of course, the patient isn't necessarily the source of revenue. An alternative view, therefore could be that 'customer' can be thought of as composing of various stakeholders. There are the primary customers who consist of those who attend/use or could attend/use organisations, and a secondary customer type which comprises other stakeholders such as funding bodies, employers etc. In the context of Healthcare, there would, therefore, seem to be a need to look more deeply into what can be termed, 'customer', and in particular, the degree of customer orientation required of successful relationships. The need for the development of long-term relationships becomes important not only with resource providers but also with other 'customers'. Using a number of relationship exchanges specifically linked to a not-for-profit context Conway and Whitelock (2007) bring together the work of Morgan and Hunt (1994) and Gwin (1990) and develop a conceptual framework. See Figure 1 in the Appendix for this to be applied to Healthcare in a 'local' context.

4. The Research Context:

4.1 Putting devolution into Context

Recently there has been an acceptance in the UK that services need to be more tailored for local need (NHS England *et al* 2014). and with it the concept of devolution has been brought to the table. At the forefront of this has been Greater Manchester where local leaders signed a deal with central government in 2014 and when for the first time health care budgets and decision making were shifted from central government to regional control in the Greater Manchester area. This recognised the fact that decisions to best meet the needs of the population are best made locally. In 2017, the region was responsible for a health and social care budget of £6bn. With a population of 2.8 million residents, the ten authorities comprising Greater Manchester have long worked in collaboration through the Association of Greater Manchester Authorities (AGMA) (Kings Fund, 2015). Alongside this has been a similar background of close working relationships in health and social care organisations which led to formal integration between health and social care services, (Healthier Together 2015). This record of

collaboration led to it being in an ideal position to become the first city region in the UK to have certain powers devolved to them from central government.

Devolution has offered leaders an unprecedented opportunity to look at new ways of service design, taking on a far more holistic approach than has previously been the case. The Greater Manchester Health and Social Care Partnership comprises not simply health and social care agencies such as NHS and local authority, but also the community, voluntary and social enterprise sector as well as Greater Manchester Police and the Greater Manchester Fire and Rescue Service. However, in setting its strategic aim, it also acknowledges the role that education, work and housing contributes to the wellbeing of the population and so the partnership is working to ensuring an alignment between services. This shift represents a new way of working which is essentially about introducing greater accountability and a more inclusive, collaborative approach at local level, so that ' different organisations from the health and care system work together to improve the health of their local population by integrating services and tackling the causes of ill health', (Charles, 2018). It has been argued that this shift to integration is fundamentally tied up with the quality of patient care and outcomes and that this in turn depends on 'leadership across organisations and working with others.. within and throughout organisations',(Timmins, 2015 p 6). Together these are driving a new direction for service provision within the sector.

This pluralistic approach offers increased opportunities for increased innovation in an environment where emphasis is increasingly being placed on prevention rather than cure. Leaders argue that current strategy has been focused on care has being 'over medicalised' (Patel, 2016) and should shift from simply treating sickness to promoting good health and wellbeing through innovative new thinking and by working with the other services which have devolved budgets. This over medicalisation is reflected in the traditional model of care which emphasises acute care while the wider issues of environment, housing, education has been emphasised less. This is now being turned on its head, with community strategies including engagement environment, housing and education now being emphasised much more. The health and social care plans for Greater Manchester focus very clearly working in a pluralistic manner to reduce inequalities, improve life chances in the quest to improve health and wellbeing of the population and a number of themes have been identified which clearly focus the partnership's direction towards work in innovative new ways to achieve the aims that it has set. It is not about taking away the opportunity to have face to face consultation but to open up other channels.

4.2 : A pluralistic and integrated model

The Greater Manchester Health and Social Care Partnership is a working example of maximising the opportunities this paradigm presents. Nevertheless, a pluralistic style doesn't come without challenges such as organisations having their own governance arrangements and differing objectives and the widely differing nature of staff between organisations (in health care they are likely to be more highly qualified and used to

working with a level of autonomy while in social care they are lower paid and have less qualifications and the third sector relies on the varying skills of volunteers)

5. The proposed research

This research therefore aims to look at how such integrative approaches can be implemented and then effectiveness of such an approach can be assessed. An exploratory research design is considered appropriate given the lack of prior information in the area. The aim is to identify principal themes, patterns and links which could be used as a basis for a more detailed study of the relationships that exist between stakeholders in the Greater Manchester locality. This preliminary study focuses on the meaning of senior managers' experiences of the concept of 'effectiveness' via semi-structured interviews.

References

Bengoa, R. & Kawar, R. (2006), Quality of Care - A policy for making strategic choices in health systems. Geneva: World Health Organisation.

Birks D.F and Southan, JM (1991), 'The potential of marketing information systems in charitable organisations', *Market Intelligence and Planning*, 8 (4), pp15-20

Charles, A, (2018), Accountable care explained, 18 January, King Fund, London

Christopher, M, Payne, A and Ballantyne, D (2013), *Relationship Marketing: Creating Stakeholder Value*, Taylor Francis

Conway, T., & Whitelock, J. (2007). Relationship marketing in the subsidised arts: the key to a strategic marketing focus?. *European Journal of Marketing*, *41*(1/2), 199-222. doi:10.1108/03090560710718184

Evans, D. B., Edejer, T. T.-T., Lauer, J., Frenk, J. & Murray, C. J. L. (2001). Measuring quality: from the system to the provider. *International Journal for Quality in Health Care,* 13**,** 439-446

Frow, P., McColl-Kennedy, J. R., Hillton, T., Davidson, A., Payne, A & Brozovic, D (2014). Value propositions: A service ecosystems perspective. *Marketing Theory,* 14**,** 327-351.

Gwin, J.M., (1990), "Constituent Analysis: A Paradigm for Marketing Effectiveness in the Not-for-profit Organisation", *European Journal of Marketing*, Vol. **24**, No. 7, pp. 43-48.

Healthier Together (2015). Consultation: your views [online]. Healthier Together website. Available at: https://healthiertogethergm.nhs.uk/decision-about-change/your-views/ (accessed on 7th January 2018).

Lusch, R. F. & Webster, J. F. E. 2011. A Stakeholder-Unifying, Co-creation Philosophy for Marketing. *Journal of Macromarketing,* 31**,** 129-134.

McColl-Kennedy, J. R., Vargo, S. L., Dagger, T. S., Sweeney, J. C. & Van Kasteren, Y. 2012. Health Care Customer Value Cocreation Practice Styles. *Journal of Service Research,* 15**,** 370-389.

McKenna, F., Dunn,P., 2015, Devolution: what it means for health and social care in England, Kings Fund

McColl-Kennedy, J.R., Vargo, S.L., Dagger, T.S., Sweeney, J.C. and Van Kasteren, Y. 2012, Health Care Customer Value Cocreation Practice Styles, *Journal of Service Research,* Vol 15, pp 370-389

Morgan, R.M. and Hunt, S.D., (1994), "The Commitment-Trust Theory of Relationship Marketing", *Journal of Marketing*, Vol. **58**, July, pp 43-48.

NHS England (2014), Five Year Forward View, London

Patel R., 2016 The future for primary care in Greater Manchester Westminster Health Forum, Manchester

Pinho, N., Beirao, G., Patricio, L. & Fisk, R. P. 2014. "Understanding value co-creation in complex services with many actors". *Journal fo Service Management,* 25**,** 470-493.

Shapiro B.P m(1973), 'Marketing for nonprofit organisations' ,*Harvard Business |Review*, Sept/Oct, pp123-132

Stevens, R,E, Loudon, D,L and Miigliore R,H (2013), *Strategic Planning for Not-for-Profit Organisations*, Routledge

Sweeney, J. C., Danaher, T. S. & McColl-Kennedy, J. R. 2015. Customer Effort in Value Cocreation Activities: Improving Quality of Life and Behavioral Intentions of Health Care Customers. *Journal of Service Research***,** 1-18.

Timmins, N, (2015, May), The practice of system leadership-being comfortable with chaos, Kings Fund, London

Vargo, S. L. & Lusch, R. F. 2011. Stepping aside and moving on: a rejoinder to a rejoinder. *European Journal of Marketing,* 45**,** 1319-1321.

Appendix: Fig.1 Relationship Approach to 'local' UK Health Care (adapted from Conway and Whitelock, 2004)