Title:
Marketing management at Uppsala University Hospital.
A case study in Swedish health care marketing

Authors: Carina Olausson & Per-Håkan Olausson

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Abstract

Aim:
The overall aim of this study was to obtain more knowledge on the implementation of health care marketing in Sweden, using Uppsala University Hospital (UUH) as a case study. Additionally, based on the results of this case study, the aim was also to give concrete suggestions on how to enable increased focus on the formulation and implementation of health care marketing management strategies. This gives the study a slightly normative approach and aim, since the line is
not drawn at description and analysis but also advocate guidelines for the enabling of market orientation.

**Method:**
The chosen methodology of the study was qualitative, as the study sought to explore, interpret and gain a deeper knowledge of the research area. Three different strategies of primary data collection were used; (1) interviews with key hospital managers, (2) a survey sent to all heads of clinical departments (68 departments) and (3) the study of selected UUH internal documents and UUH internal material related to the subject. The massive data was consolidated, reported and analyzed as separate parts and as well as an overview analysis from a health care marketing management theoretical framework.

**Results & Conclusions**
The study showed that UUH, despite the fact that they produce an annual revenue from health care services sales of approx 1,5 billion SEK, lacks almost every aspect of the tools and abilities necessary to function on a competitive marketplace. This included a non-marketing based planning process, the absence of a marketing organizational unit, no marketing research abilities etc. There were also facts pointing at severe flaws in the accounting systems, uncertainties of the legality of the current marketing activities and no marketing-stimulating incentive-systems in place. Besides these hard facts, the conservative, non-market oriented, organizational culture was deemed to make an attempted marketing adaption very hard to implement. The
interviews provided valuable data for the structure and analysis. The survey had a very low response-rate, which didn’t provide any valuable data per se, but was interpreted to support the analysis of the organizational flaws in regard to marketing orientation. The internal document study also resulted in support of this analysis and increased the validity. Based on the analysis, a suggestion for a “road map” to successfully market-adapt Swedish health care was presented.

**Suggestions for future research:**

Health care marketing most likely constitute its own area of research which also is specific for Sweden, which gives infinite opportunities for further studies. The implementation of marketing strategies in health care is an area that really needs to be further studied, therefore a suggestion for future research is to try and find out just how to enable implementation of a marketing-orientation in an organization which never had one. Another suggestion for further research could be the study of how economic incentive systems and other means of co-worker stimulation influence the production of health care services.

**Contribution of the thesis:**

We believe that this study will strengthen the marketing understanding for UUH personnel at both managerial as well as all other organizational levels that are interested in the subject. We also believe that politicians, both locally and nationally, will benefit from practical knowledge regarding health care marketing mechanisms currently in place. Though conducted as a case study at one hospital, we deem that
the analysis and suggestions are applicable for many other health care providers acting on the Swedish health care services marketplace, possibly contributing to the development of Swedish health care.

Key words:
Health care marketing, Marketing management, Uppsala University Hospital

TABLE OF CONTENTS
1. Introduction .................................................................6
  1.1 Uppsala University Hospital (UUH)...............................6
  1.2 Uppsala Care (UC)......................................................7
  1.3 The Swedish health care system ...................................7
2. Problem and aim ..........................................................13
3. Research questions .......................................................14
4. Scope of Study / Limitations ..........................................14
5. Theoretical discussion ....................................................16
  5.1 Marketing management – the concept .........................16
  5.2 The SWOT analysis ..................................................17
  5.3 Health care marketing ..............................................18
6. Data collection ..............................................................33
  6.1 Semi-structured interviews .......................................34
  6.2 Survey to department-heads ......................................36
  6.3 Internal documents and internal material review ..........36
  6.4 Validity .................................................................37
  6.5 Reflections regarding the data collection method ..........38
7. Empirical study ............................................................39
  7.1 Results from interview material .................................39
  7.2 Results from survey to department-heads ..................48
  7.3 Results from internal documents and internal material review 51
  7.4 Reflections regarding results from the data collection ....54
8. Analysis / Discussion .....................................................54
  8.1 Regarding marketing management priority .................54
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.2 Marketing organization and strategies</td>
<td>56</td>
</tr>
<tr>
<td>8.3 Regarding accounting</td>
<td>58</td>
</tr>
<tr>
<td>8.4 Regarding incentives</td>
<td>59</td>
</tr>
<tr>
<td>8.5 Legislation and regulation in regard to marketing management</td>
<td>60</td>
</tr>
<tr>
<td>8.6 Ownership</td>
<td>61</td>
</tr>
<tr>
<td>8.7 Reflections regarding the analysis / discussion</td>
<td>62</td>
</tr>
<tr>
<td>9. Comments / Conclusions</td>
<td>63</td>
</tr>
<tr>
<td>9.1 Current health care marketing status at UUH</td>
<td>63</td>
</tr>
<tr>
<td>9.2 A road map to market adapt Swedish health care</td>
<td>66</td>
</tr>
<tr>
<td>9.3 Final reflection and suggestions for future studies</td>
<td>71</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>73</td>
</tr>
<tr>
<td>References</td>
<td>73</td>
</tr>
<tr>
<td>Figures and Tables (list of references)</td>
<td>77</td>
</tr>
<tr>
<td>Appendix I - Interview questions</td>
<td>78</td>
</tr>
<tr>
<td>Appendix II – Survey questions</td>
<td>80</td>
</tr>
<tr>
<td>Appendix III – Data extracted from UUH annual report 2008.</td>
<td>81</td>
</tr>
<tr>
<td>Appendix IV – Data extracted from UUH operational plan for 2009.</td>
<td>83</td>
</tr>
<tr>
<td>Appendix V – UUH operational plan for 2010 (draft)</td>
<td>86</td>
</tr>
</tbody>
</table>
1. Introduction

1.1 Uppsala University Hospital (UUH)

Uppsala University Hospital is Sweden's oldest university hospital. The first department was established as early as 1708. Today, the hospital is one of the country's most complete regional hospitals, with around 40 departments and over 8,200 employees. Its main fields of activity are medical care, teaching and research. The total yearly turnover is about 6 billion SEK.

The hospital provides education for a broad range of professionals; amongst them are doctors, nurses, physiotherapists etc. The hospital provides professional training each year for more than 1500 health-care professionals.

Uppsala University Hospital in brief:
- 1,100 beds
- 8,000 employees
- 8,000 patients treated for various cancers
- 56,000 admissions per year
- 300,000 doctor appointments per year
- 350,000 treatment procedures per year

Figure 1; Source: UUH, 2009

Research is being conducted at the hospital in close collaboration with the medical faculty at Uppsala University. The research is an integrated, natural part of the daily work, both for patients and personnel. The hospital also has an extensive collaboration with the
pharmaceutical industry and every year more than 100 clinical trials of new drugs are started at UUH. [UUH, web site, 2009].

**1.2 Uppsala Care (UC)**

Uppsala Care is UUHs internal marketing unit for sales of care to *international* patients. UC is commissioned by UUH to address these primary areas;

- To be responsible for service and logistics regarding planned healthcare for non-Swedish citizens.
- To strengthen UUHs brand internationally and to market UUHs services internationally
- To contribute to and assist in the development of highly specialized health care so that a high capacity can be continuously maintained and therefore keep a high competence profile.
- To promote the sales of international health care.

The unit has two administrative personnel and access to one part-time medical advisor. The services are produced by other organizational units / clinics at the hospital and UC provides the sales-support and all administrative tasks related to the care of international patients. [Source: Internal work-documents, Uppsala Care]

**1.3 The Swedish health care system**

All citizens of Sweden have more or less equal access to health care services. The Swedish health care system is funded by the government and is greatly decentralized. Compared with other countries at a
similar development level, self-assessments consider the system can be a strong performer, with good medical results in relation to investments despite cost restrictions. [SALAR 2005]

International comparisons are hard to evaluate, but there has been some efforts in that area, Sweden was ranked first of 19 OECD countries when comparing standardized death rates from causes that health systems can do something about. [Nolte et al, 2003]

**Heavily decentralized**

Sweden has an incorporated public healthcare system in which nearly exclusively all financing and almost all the delivery is provided by the public sector. The main accountability lies with the 20 county councils and one local authority. [Wikipedia, 2009, “Healthcare…"] These county councils own and run most hospitals and are in charge of the delivery of primary and hospital care, including public health and preventive care.
They are each fairly small, with an average population of 275,000 people. Only three of them have more than 500,000 residents. Counties typically divide themselves into numerous healthcare districts, each of which is run by a designated board. The counties are heavily grouped into six medical care regions that are intended to improve co-operation in highly specialized care, research and training. Each region has a population of about 1-2 million and includes at least one university hospital. The counties also regulate publicly financed but privately run healthcare providers.

They control the establishment of new private practitioners and set the regulations regarding the number of patients that private practitioners may see each year and set the fee schedule that must be adhered to if a private provider wishes to be reimbursed by the social insurance

**Figure 2:** The organization of Swedish health services

Source: The Swedish Institute, 2007
system. Nearly all primary care is publicly provided. Only a quarter of outpatient consultations are carried out in private facilities, and most of those are situated in the larger cities and have written agreements with the county council. Solely private primary care is quite rare. Long-term psychiatric care and elderly care as well as the disabled are the responsibility of the 289 local authorities (municipalities). The government (through its National Board of Health and Welfare) plays a part by setting national goals and guidelines, although these are not at all times implemented consistently across the country [SALAR, 2009, “Hälso …”].

**Tax financed health expenditure**

Health expenses are financed mostly through income taxes, with the private funding share (about 15%) below the OECD average but similar to that of the other Nordic countries. Out-of-pocket spending is clearly below the OECD average. It is approximately 10% of the total (based on the household expenditure survey, which found that 2% of the households’ disposable income was spent on healthcare in 1999). Private health insurance is still almost non-existent, covering less than 1% of healthcare costs [SALAR, 2005]. Largely, the financing of the system is close to proportional, i.e. neither pro-rich nor pro-poor.

After total health spending has been much higher than in almost any other country throughout the 1970s and 1980s, it is now in line with the level that would be expected considering Sweden’s GDP per capita. Health spending was very restrained from the mid-1980s to the
mid-1990s, reflecting a general need to restrict the health sector and the fallout from the fiscal crisis in the early 1990s that led to severe cutbacks through the whole public sector. In healthcare, a large contribution to cost control came from a structural reform in 1992 in which the accountability for elderly care and some other functions was transferred from counties to municipalities. Due to this process, a large number of elderly “bed blockers” were moved from acute care beds into either home care or public nursing homes. Despite this shift, there is a general impression that the Swedish system is still tilted towards hospital care rather than primary care, although it is difficult to back that up with solid evidence [De Graeve et al, 2003].

The period of expenditure restraint seemed to have come to an end after the year 2000. Spending surged by 23% between 2000 and 2003, which is particularly remarkable considering that increases in pharmaceutical costs was subdued. This jump far outstripped the increase in the volume of services, indicating that much of this extra cash has gone into either higher wages and prices, or lower productivity, rather than generating an increase in output (although there is some insecurity regarding growth in the volume of services) [Gerdtham et al, 1996]

Legal framework
Through municipal and regional self-government, municipalities, county councils and regions achieve local and regional democracy
which, together with a democratic form of government, forms the foundations of Swedish democracy.

UUH is an organizational unit under the management of Uppsala county council that by Swedish constitution has an independent power of taxation. The responsibilities of the county are regulated partly in the Local Government Act [Swedish Justice Department, 2000] and partly in laws and ordinances such as for example the health and medical services act [Swedish Ministry of Health and Social Affairs, 1982]. These laws and other ordinances regulate a few principles, creating a framework for UUH to operate within.

A few principles in these laws are of great importance for UUH health care marketing. These are for example the principle of excessive production in the Local Governance act, stating that UUH is not allowed to build excessive capacity with the purpose of marketing, only to sell temporary excessive capacity. Another interesting principle affects the price of the services marketed, and that is the principle of cost price (prime cost, full cost) pricing, stating that no profit is allowed when pricing the products.

The most interesting principle related to health care marketing may be the principle of equal treatment in the Local Government Act, this principle basically forbids UUH and other publicly governed hospital to sell health care services to privately paying customers within
Sweden, which includes insurance companies. UUH is therefore only allowed to service tax- (publicly-) financed Swedish citizens.

2. PROBLEM AND AIM

Sweden has experienced and is experiencing the great challenge of dealing with the fact that we have a very large increase in the percentage of elderly in the population [Berleen, 2004]. Consequently, there is a large and growing demand for a variety of health services. Sweden needs to assess the future resources needed and the need for changes of the health care system. [SALAR 2005] The basis for funding health and medical care is local taxation, which means that opportunities for economic expansion are limited, and cost restrictions are a must. It is critical to maximize existing resources. [The Swedish Institute, 2007] The pressure has started to rise, and a series of national and local reforms have been initiated.

Due to these factors, it is vital to provide for future health care needs in a more cost-effective way. An important tool which can aid in meeting these challenges and to obtain a more cost-effective way of managing Swedish health care in a longer perspective is to put focus on the formulation and implementation of health care marketing and its strategies [Berkowitz, 1994 & Narver and Slater, 1990].

Today, it is more important than ever for hospitals and other care providers to adhere to the vastly changing health care marketplace, in order to ensure survival. Due to the fact that this area of research is
quite new in Sweden, and hence the basic existing knowledge, we have chosen a probatory approach to this project. However, there will also be a slightly normative approach and aim, since we will not draw the line at description and analysis but also advocate guidelines for the enabling of market orientation.

The overall aim of this research can simply put be to obtain more knowledge and based on this, give concrete suggestions on how to enable increased focus on the formulation and implementation of health care marketing management strategies for UUH, a hospital acting within the boundaries of the Swedish health care system.

3. RESEARCH QUESTIONS
- What health care marketing strategies are currently defined and implemented at UUH?
- Can any obvious improvements be identified regarding health care marketing at UUH?

4. SCOPE OF STUDY / LIMITATIONS
There will be a focus on the "inner" marketing-operations of UUH, which will exclude in-depth contemporary social and environmental analysis. There are of course other factors than the ones we deemed to be the most essential and hence included in this thesis, however, the inclusion of all possible factors would make the scope of the study too wide, and we have to draw the line somewhere. Our aim is more to provide a base-line for further health care marketing research, which
for example could include an in-depth contemporary social and environmental analysis.

In order to acquire presumable expert opinions and map what level of knowledge on the subject key members within UUH has, qualitative interviews have been conducted with a chosen few.

The number of interviewed is limited and has not been determined based on a minimum number necessary to ensure repetition-effect in responses, but this is not necessary for this type of study-methodology.

In addition, due to the fact that there also will be a survey presented, that this study is qualitative, and the overall aim of this research is to obtain a knowledge base-line, (since there is practically no prior academic knowledge available), we are confident the results from both the interviews and survey will provide a good basis for the empirical study and analysis.

In order to establish what prior research had been done in Sweden on the subject a thorough literature review was performed. Based on this, we could conclude that the topic for this project is generally not very well documented, particularly not with regard to the Swedish market. For this reason many of the articles and much of the literature we refer to throughout this paper originate from the US, for the simple reason that they introduced the concept of health care marketing more than 30
years ago, while this concept is brand new in Sweden. There is of course certain disadvantages with this, because of the fact that the articles/literature is based on market conditions and a health care system that differs in many ways from the ones in Sweden. However, we will remain aware of this fact during the course of this entire project, and will take this into consideration when we analyze the data collected and make recommendations/draw conclusions. Overall, there are rather few available studies and literature related to this area of research internationally included, but we will not view this as an obstacle to investigate this particular subject, but as a strong indication that there really is a need for more research in this field, and that this project hopefully is somewhat pioneering.

5. THEORETICAL DISCUSSION

5.1 Marketing management – the concept

Marketing management is a business discipline focused on the practical application of marketing techniques and the management of organizations marketing resources and activities [Kotler, P.; Keller, K.L, 2006, p 31] Marketing managers are often responsible for influencing the level, timing, and composition of customer demand accepted definition of the term. In part, this is because the role of a marketing manager can vary significantly based on a business size, corporate culture, and industry context. For example, in a large consumer products company, the marketing manager may act as the overall general manager of his or her assigned product.
From this perspective, the range of marketing management is quite broad. The implication of such a definition is that any activity or resource the organization uses to gain customers and manage the corporations’ relationships with them is within the purview of marketing management. Additionally, the Kotler and Keller definition encompasses both the development of new products and services and their delivery to customers [Kotler, P.; Keller, K.L, 2006]

Marketing expert Regis McKenna expressed a similar point of view in his influential 1991 Harvard Business Review article "Marketing is Everything." McKenna argued that because marketing management encompasses all factors that influence a corporation’s ability to deliver value to customers, it must be "all-pervasive, part of everyone's job description, from the receptionists to the Board of Directors." [McKenna and Regis, 1991]

This standpoint is also consistent with the perspective of management guru Peter Drucker, who wrote: "Because the purpose of business is to create a customer, the business enterprise has two-and only these two-basic functions: marketing and innovation. Marketing and innovation produce results; all the rest are costs. Marketing is the distinguishing, unique function of the business." [Drucker, 1993]

5.2 The SWOT analysis
The SWOT analysis dominated early strategic planning models, and became especially popular during the 1970s and 1980s as the concept
and role of planning evolved in response to environmental challenges. SWOT gave rise to related planning models like the PEST and Porter’s Five Forces. Newer models focus on strategic agility and the importance of strategic thinking and organizational learning, rather than on the static planning models of the past. Still, the SWOT remains a cornerstone of strategic planning with its appealing ease of use [Trainer, 2004].

The SWOT method is broadly applicable and is also widely used in public organizations, by small teams and by individuals in almost all kinds of development of strategies [Sörensen & Vidal, 1999].

5.3 Health care marketing
Health care marketing is today known internationally as a functional discipline, which also should be included in managing health care organizations. Although not always practiced effectively (or practiced at all as in the case of most Swedish hospitals historically), the perception that marketing is more than advertising has gained increased recognition. Since the concept was first introduced in the same context as health care more than three decades ago, the health care marketplace has gone through dramatic changes [Berkowitz, E.N, 2006, p XI] Now, as we move deeper into the 21st century, the system is undergoing even more transformations, whereby a greater responsibility of the care cost distribution is being shifted back to consumers, through allowing the individual patient to freely choose care provider to a much greater extent, which will inevitably result in
increased demands regarding the hospital care, service, management and marketing in order to be the most attractive option for consumers.

Now, as we will begin to see the ultimate user, the consumer, choose care provider more freely [SOU, 2008:37] they will likely become more sensitive to the care provider brand and the service provided, which also may move health care services closer to other industries. In addition, increased demands with regard to the individual service providers (for example doctors) ability to market-communicate can be expected, particularly in a competitive situation. And, due to this, the marketing concepts as practiced in other industries also have ever greater relevance and should also apply to health care providers. Relevant questions for health care organizations at this time become; what is the value being provided to the consumer? What customer does the organization want to reach? Once that customer is gained, how can the care provider build a relationship with the customer so that if appropriate care is needed again they will return to that particular care provider (relationship marketing)? These are basic marketing issues faced in a somewhat different way by hotels, computer manufacturers, and now also health care providers. However, it is important to consider the underlying limitations and influence of the fact that health care providers are bound by a different set of rules than other industries.

The health care industry is quite dramatic in the pace of change. Today, countries worldwide face global competition, or the increased
opportunity to gain foreign customers. Possibly, the greatest impact on
all providers of care and health care organizations is in the home of
every potential patient and at the fingertips of every potential buyer of
health care services - the internet through their computer. This
technology portal provides access to data on competitors, quality, and
prices and can alter purchasing behaviors in ways that make strategy
more complicated for any organization. Marketing will be more
complicated and more essential to succeed. [Files, L.A., 1988]

As health care marketing first came to the US health care industry in
the mid seventies- an everyday concept today- it was considered novel
and controversial. Now, more than 30 years later, marketing has
spread throughout health care into American hospitals and other health
care organizations [Berkowitz, E.N, 2006, p 2]

**The significance of health care marketing**

There are several views and definitions of marketing. The most widely
accepted definition is that of the American Marketing Association (at
least according to American marketing literature), which defines
marketing as “the process of planning and executing the conception,
pricing, promotion, and distribution of ideas, goods, and services to
create exchanges that satisfy individual and organizational
objectives.“ [Benett, P.D., 1995]

Fundamental to this definition of marketing is the focus on the
consumer, whether that is an individual patient, physician or
organization. This definition also contains the key ingredients of
marketing that can be claimed to lead to customer satisfaction. Increasingly in health care, customer satisfaction is considered the key issue.

The Joint Commission on Accreditation of Healthcare Organizations, the American industry’s major accrediting agency for operating standards of health care facilities, required – in its 1994 accreditation manual – that hospitals improve on nine measures of performance, one of which is patient satisfaction. This focus on patient satisfaction for hospital accreditation can be viewed as an overt recognition of the need for health care facilities to be marketing oriented and, thus, customer responsive. [Joint Commission, 2009]

The predicament of needs and wants
One of health care marketing’s key concerns pertains to the issues of needs and wants. Health care professionals often speak of the fact that what consumers want may not be what they need. Clinical and professional responsibility demands treatment of the need. A need can be defined as a situation in which there is an insufficiency of something or a physiological or psychological requirement for the well-being of an organism. [Merrian-Webster, 2009]. A want can be defined as the craving or wish for something [yourdictionary.com, 2009]. A consumer needs to have medication for hypertension or needs surgery because of appendicitis. A person may want medication to suppress the appetite and thus lose weight or may want cosmetic surgery to reshape the nose. To which need or want should the health
care marketer respond? Underlying any response in health care must be whatever constitutes providing quality care for the patient. Meeting medical needs must be the primary purpose of the system. Yet wants should not be ignored. Unsurprisingly this can sometimes be a difficult balance to uphold.

The non-marketing determined planning procedure

As illustrated in Figure 3, non-market-based planning sequence is a method for long-range planning, applicable to describe the traditional planning process of Swedish health-care. Even if hospital administrators have come to an understanding that there may be a market that are defining the success (sales) of the hospital’s services, the template used when planning ahead is the traditional non-marketing determined planning procedure.

This culture doesn’t only has its origin from the hospital administrations tradition, but from the fact that this model also is used by the owner (the County council) when

**Figure 3:** Illustration of the nonmarket-based planning-process, Source: Berkowitz, E.N, 2006, p12
planning for necessary taxation. [Director, Uppsala University Hospital, 2009] [Landstinget Uppsala Län, 2008]

This model is apparently different from a market/customer-driven planning process and this difference is an important factor to understand when studying the hospital management from a marketing perspective. It is therefore very important to recognize the implications of the difference between the two concepts on long-range planning [Berkowitz, 1994]

In a non-market driven planning process, the first step is to set mission and goals. First, mission and goals are set. Besides from receiving specific mission and goals from the county council, the hospital assigns work-groups or committees comprising of administrators, members of the board of directors and other key managerial personal that sets or suggests goals for the hospital one year at a time.

After that, or as a parallel process, strategies are formulated on how to fulfil the mission and goals. The next step of implementation, is started at all levels of the organization and may be difficult, as the mission and goals has to be translated into actionable steps, applicable for anyone in the organisation and supposedly match with economic realities at each organizational level.

This approach to delivering a service or health care product can be described as an internal-to-external process. A fixed product, with a
fix quality, financing etc is planned and produced regardless of the actual market-price or customer’s willingness to buy. This process may work for the tax-financed services provided to the inhabitants under the county-council responsibility, but is a very high-risk approach when trying to actually sell the products outside the county-councils area. The forecasting-ability of key managers is of greatest importance for the business to be successful. [Berkowitz, E.N, 2006, p 12]

The marketing determined planning procedure
The solution to many of the problems related with a non-marketing determined planning process is to convert the planning process to a market-driven planning sequence. This is different in almost any aspect, demanding a quite different mindset of all people involved in the work. The market-driven planning process is illustrated in Figure 4, where only the first step of the process has the same label (though, mission and goals probably has a

Figure 4: Illustration of Market-driven planning-process, Source: Berkowitz, E.N, 2006, p15
different meaning for the market-oriented mind). At step two, the market research department contributes with key facts to the planning. This may include both business-to-business market research and consumer marketing research and need reliable methods of obtaining, measure and analyze the marketing data. [Wikipedia, 2009, “Marketing research”] To take the next step, the organization must be willing to adapt and match its service offer to the areas where the market analysis identified a competitive advantage. The model later incorporates a validation-step (pre-test) to try the quality of the marketing analysis. Pre-testing involves selling a product to a test-market to ensure that the product meet customer expectations. This step is a particularly complex task in a health care business, but a detailed concept description of the service presented (with a price tag) to potential buyers, may be enough. If pre-testing is judged successful, the implementation can begin. At this point, the hospital needs to market the program through appropriate channels determined by the marketing-department. [Flexner Berkowitz, 1979].

The emerging marketplace of health care

“It is not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change”

Charles Darwin

There are many forces impacting on the management of healthcare organizations. These forces are the most critical: financial, the health
perspective, politics, proficiency and experience, value for money, consumerism, media, social accountability and business ethics.

The economic climate can be considered the most important factor, as well as the economic system of the country, including ideological aspects. Obviously a country’s economic ability, economic prosperity, levels of economic development and industrialization, economic growth and dependence on international economic aid, as well as the national and international economic trends and crises, have a vital influence on the healthcare system and the management quality in the health care system.

Any organization or business is therefore a component of the economic system, and is also subject to the economic principle.

The health care organization is no exception – limited resources need to be maximized to achieve the maximum result and outcomes in a very complex healthcare context [Muller et al, 2006, p2]

Health perspective holds important consequences for both the health status and the health behavior of the consumers, as well as for the nature and organizations of health systems and the management of the healthcare organizations. The health knowledge, health beliefs and health attitudes are important forces impacting on the management of a healthcare organization.

Successful management of a healthcare organization is dependent upon the competence of all employees. Industry experience –
especially regarding managers – is also vital. Managers have different roles and it is necessary for them to have both general and specific abilities, such as knowledge, skills, attitudes and values.

The following key abilities are recognized as pre-requisites for good management:

*Conceptual abilities.* These include the mental capacity to view the business/organization in a gestalt/holistic manner, thus, with an interest in the individual or society as a whole. This ability mainly relates to thinking, analytical and planning skills.

*Interpersonal abilities.* These include the people-skills required to lead, facilitate and motivate the employees to fulfilling goals in the organization.

*Technical abilities.* These include the application of several sciences in the healthcare organization by utilizing and integrating operational information to facilitate the quality of service delivery and the management of the healthcare institution [Muller et al, 2006, p 2-3]

The understanding, values and attitudes related to health in a community influence the patients’ perceptions and expectations on value for money as well as excellence [Elshaug A.G et al, 2009]

Consumerism is a social force that protects consumers against unsafe products and malpractices by exerting moral and economic pressure on businesses and organizations [Arnould EJ and Thompson CJ, 2005]
The social accountability of an organization is a concept that originated in media revelations of malpractices by organizations and the resulting assertion of society on restricting such malpractices through regulation. Social accountability has been included in the principles of corporate governance and all healthcare organizations need to adhere to this [Wikipedia, 2009, “Corporate...”]

Business ethics is closely related to social accountability except that business ethics focuses specifically on the ethical behavior of managers and executives in the business world. Business ethics revolves around the faith that society places in people in businesses, and the obligations the latter have towards society. Factors such as greediness, workers and consumers exploitation, and the abuse of positions of confidence have often resulted in the business ethics of managers and practitioners being deplored, threatening the legitimacy. High-standard business ethics are considered a critical part of successful health care marketing. [Engelhardt HT and Rie MA, 1988]

**The keys to successful health care marketing**

Marketing theory and education begins with the four mechanisms of marketing. These mechanisms have application for marketing any product or service, including healthcare to a certain extent. The core in marketing strategy is the development of an answer to the marketplace. As apparent in the definition, marketing is the “execution
of the conception, pricing, promotion, and distribution of the goods, ideas and services.” To respond to customers, an organization must develop a product, establish how much customers are willing to pay, identify where it is most convenient for customers to access the service, and finally, promote the product to consumers in order to make them aware it exists. Product, price, place and promotion are referred to as the four Ps of marketing strategy [McCarthy, 1960]. It is these four controllable variables that a corporation uses to define its marketing strategy. The mix of these four controllable variables that a business uses to pursue a preferred level of sales is referred to as the marketing mix.

*Product* represents goods, services, or ideas offered by a corporation. The term “product” can also be applied on health care services and ideas with certain modifications.

For example; physicians and hospitals offer services. The services include both the diagnosis and treatment of diseases. Services also include elective procedures that patient’s want, like procedures requested by foreign patients via Uppsala Care. In health care, one can define the product as a medical procedure or as a medical device to correct a physical disability.

*Price* focuses on what customers are willing to pay for a service. A company provides a service and customers pay money for receiving a service that satisfies their needs. The pricing matter of health care
services has become an increasing concern of marketing strategy as
the health care environment changes. A number of issues are adding to
the greater role that pricing is playing in forming a marketing strategy.
An example is the American experiment pay-for-performance model
being attempted by Medicare. A number of medical groups are
participating in this three-year pilot program in which the organization
will receive a bonus based on achieving a higher health status for the
patients [Kolata and Abelson, 2005]. For marketers, the issue of price
involves understanding what level of money a customer is willing to
exchange for the receipt of a want-satisfying service. In the current
health care climate, deciding the value of these services which is
represented by the price is a challenge facing health care
organizations.

*Place* represents the manner in which goods or services is distributed
by a corporation for use by consumers [McCarthy, 1960]. Place may
comprise decisions regarding the location or the hours the medical
service can be accessed. Another aspect to consider is that in the
digital and wireless age, the entire definition of place in terms of
patient/provider interaction may also shift somewhat. However, in the
more complex situation of UUH, the location must be where the
competence and resources are (at UUH premises), which roughly
leaves decision on which hours the service can be obtained.
Advertising has in the past stood for *promotion* according to many,
and promotion has stood for marketing. Yet, as is vivid in the
definition, promotion is just a single part in marketing; promotion
itself is not marketing. Promotion symbolize any way of informing the marketplace that the organization has formed a response to meet its needs, and that the exchange should be consummated. It involves a variety of tactics involving publicity, advertising and personal selling [Thomas R.K., 2008, p19]

Necessities for organizational marketing success

Many American hospitals have problems evolving into becoming a market-oriented organization even though the concept is not really new in the US. This has often been due to that marketing has not lived up to the expectations. The discontent in marketing is most likely due to lack of understanding of what it means to be marketing driven, and of what marketing unaided can achieve. There are certain prerequisites in order to obtain marketing success, as shown in the figure below:

![Diagram](image)

**Figure 5:** Conditions for developing an effective marketing orientation (Prerequisites of marketing success), Source: Berkowitz, E.N, 2006, p23

There must be a uniting vision that is established throughout the organization (it is not enough if only the management wants to become market-oriented) concerning the necessity of an improved
marketing, as well as incentives. There must be reward-systems in place that distinguish the value of a customer orientation, and pressure to grasp and to respond to customer needs must be strong throughout the entire organization. The department agenda objectives and measurement systems should also be tied to the development of this goal. [Diamond S.L. and Berkowitz E.N., 1990]

Another important factor to ensure marketing success is the capability to be market-oriented, which includes the training and experience of a large portion of the staff, as well as devotion to improving the organizations marketing effort. All staff must be open to ideas on how to become more market-oriented and have the funds to support them. In addition to economic support, considerable time must be dedicated to developing marketing efforts and to increasing the knowledge of how these efforts interact with other organizational priorities.

A clearly stated vision of the market that is shared throughout the organization is the third, necessary, prerequisite to success. A thorough market analysis has to be performed as a first step of setting and the vision is then set according to this analysis. For example: Who are the key customers today and how can we address their needs? Who are the key potential customers and what change must the organization make to meet their needs? What are the key areas of competitive advantage? A clear, stated mission that is understandable both internally and externally is then set.
Before success is guaranteed, the organization must develop a clear set of action steps according to market needs. As a well-tried tool for this plan, a detailed marketing plan can be used that includes all the necessary strategies and tactics. This marketing plan also has to include a detailed plan of implementation and plan for addressing minor implementation difficulties.

If any of the above defined, key elements, are lacking, the organization will be inefficient or its efforts are likely to fail. [Berkowitz, E.N, 2006, p 24]

6. DATA COLLECTION

The chosen methodology of the study is qualitative (in contrast to quantitative/statistical approach), which was deemed appropriate due to the nature of the research objective, which was to explore, interpret and gain a deeper knowledge of the research area.

“Qualitative research, begins with an intention to explore a particular area, collects "data" (observations and interviews), and generates ideas and hypotheses from these data largely through what is known as inductive reasoning“[Mays and Pope, 1996].

We have chosen to use mainly three different strategies of primary data collection. These are (1) interviews with key hospital managers, (2) a survey sent to all heads of clinical departments (68 departments) and (3) the study of selected UUH internal documents and UUH internal material related to the subject.
6.1 Semi-structured interviews

To explore and to maximize the information extraction from the interviewed subjects, semi-structured interviews was performed. Thus; predefined questions was used as a framework with the possibility to bring up additional questions to explore or clarify any answers. Each interview took approx 25-40 minutes. The interviews were conducted face to face at the private office of each subject. A sound recording device was used, in addition to manual notes. The Swedish language was used.

After receiving consent from all interview candidates the interviews were recorded in order not to lose any critical information and to simplify for the interviewer.

The interviewer had relevant knowledge in interview technique, this included skills like non-directive questioning, formulation of understandable questions, probing and listening. It is likely that the background of the interviewer (medical doctor with some knowledge in marketing management) simplified and increased the quality of the interviews.

All information was handled confidentially and promise was given to the interviewed not to be individually quoted. No statistical calculations were performed due to the fact that the study was purely qualitative and descriptive.
The interview questions were designed to gain knowledge about both current and potential marketing management and are listed in Appendix I.

The interviewed was individually chosen because they were deemed key employees of UUH with regard to the area of research, and considered well informed regarding market matters. For example, two are employees of the international marketing unit Uppsala Care, two are members of the board and involved in the hospital management’s executive market committee, and one interviewed managed the department which had the hospitals largest share of sold care internationally, and hence experience. In addition, the interviewed were in fact available for an interview.

The interviewed was;

- Professor Barbro Eriksson, Head of department, The Department of Endocrine Oncology
- Dr Nils Crona, Head of division, Oncology, Thorax and Medical Division, member of the board of directors.
- Dr Per Elofsson, Head of division, Emergency and Rehabilitation Division, member of the board of directors.
- Dr Claes Mörlin, Head of department, Centre for Internal Medicine and medical advisor for Uppsala Care
- Susanne Svahn, head of Uppsala Care
6.2 Survey to department-heads

A survey was utilized/included in this study. The survey had six open questions with specific directions to what to include in the answers, allowing the responders to prioritize and evaluate which areas they deemed most interesting to explore regarding business opportunities. The survey questions are listed in Appendix II.

This survey was supported by order of the director and sent to all department heads (n=68). The responders reported back by mail and the results was compiled in a matrix and reported to the directors committee of business areas. As the committee concluded that the response-frequency was inadequate, kind reminders was issued and additional time was allowed. The answers were compiled in a matrix (in Swedish).

6.3 Internal documents and internal material review

As going through the subject and performing research to gain knowledge about the organizational structure, we came by a vast amount of internal documents related to the organizational structure and work within the organization. This was mainly publicly available reports such as annual reports, official documents such as director’s decisions, protocols etc. Though, we also received/collection a lot of other non-official documents, such as previous internal reports and memorandums, internal working-documents, briefings, presentations etc that was related to UUHs efforts to attract external customers.
6.4 Validity

One of the central issues in qualitative research is validity (also known as credibility and/or dependability). Validity involves the degree to which you are measuring what you are supposed to, more simply, the accuracy of your measurement. There is always a certain risk of negative influence on validity due to factors such as confounding, selection bias and interviewer bias. For example, threats to the validity of one’s claims exist at each of the gaps between the interviewees experience and ones eventual conclusions.

This was taken into account in the study and there are several factors that increase the validity of the study:

- Before each interview, the purpose was clearly defined and the answers were validated through feedback/confirmation to avoid misunderstanding. The interviewer also had relevant knowledge in interview technique, which included skills like non-directive questioning, formulation of understandable questions, probing and listening.

- The validation of the survey results was difficult in regard to several factors discussed in the analysis, especially due to the low response rate. Though, the low response-rate was also increasing the study’s validity as a whole, as this low response rate *per se* was supporting the analysis conclusions. The validity was also increased by discussion of the survey results in the “directors working committee for business areas”.
The study of internal documents provided additional knowledge, hopefully adding to the accuracy of the analysis.

- The selection of data from a large material could be criticized from a validity point of view. However, as the original documents are available by requisition from UUH administration, the validity is considered high.

- Translations from Swedish to English may also have affected the validity in a negative way, although the investigators had previously been educated in translation validity of scientific English and also frequently discussed the translations in order to ensure the highest possible quality.

The subject of validity is also further discussed throughout the thesis where deemed relevant.

6.5 Reflections regarding the data collection method

Before each interview, the purpose was clearly defined and the answers were validated through feedback/confirmation by summarizing each answer and asking the interviewed “is this correctly interpreted”.

The number interviewed is not critical due to the fact that this is a purely qualitative and descriptive study. We also got to interview each individual we had initially chosen would be ideal for this purpose, no one declined when asked.
The validation of the survey results is a difficult task. It is safe to assume that the responders may have chosen to answer in a way that was favorable for them, thus excluding negative opinions. One form of validation was a discussion about the results in the “directors working committee for business areas”, and board meetings in which the interviewer took part.

Regarding the internal documents; some of these documents were used as background material and referred in empirical data, but most could not be referred and therefore only used to provide us with additional knowledge, hopefully adding to the accuracy of the analysis.

7. EMPIRICAL STUDY

7.1 Results from interview material

Transcripts, notes and interview material were condensed to reflect key issues pressed by the people interviewed.

Regarding marketing management priority

Everyone rated marketing activities to be currently of very high importance. References were given to the current situation with UUHs economy being dependent of customer’s willingness to pay for the services.

Everyone also rated the importance to grow in the years to come. Examples of this opinion was;”patients will be more selective about the choice of health care provider – thus the marketing will matter
more and more in that choice”, “neighboring counties, traditionally buying large volumes without comparing service or pricing, will be more selective about each purchase – price, promotion and general marketing will play an important role in that choice”

The successes of the marketing efforts were generally rated as a matter of survival for the hospital in its current structure as the tax-financed, county-council based economy was considered insufficient to maintain the hospitals competitive ability. References were given both to maintaining current level of care and the ability to expand highly-specialized key areas.

Two of the interviewed considered UUH to have a competitive disadvantage compared to Stockholm´s hospitals when considering the marketing efforts, due to Stockholm’s greater media exposure.

**Regarding marketing organization and strategies**

The interviewed were all pointing out the fact that UUH didn’t have a marketing organizational unit. There were also opinions about the facts that UUH lacks market research, lacks a marketing plan and essentially are missing the customer perspective in almost all organizational levels. The efforts the organizational unit “Uppsala care” performs are considered too low prioritized and limited to international market. No dedicated personal or organizational unit that focuses on the Swedish market can be clearly identified.
Some had the opinion that UUH needed to create a dedicated marketing unit and was in pressing need to recruit external, professional marketing competence.

The majority pointed out that they considered marketing competence to be centralized in the organization to create a consistent marketing message and pool marketing resources, but a majority also pointed out that such a unit had to be in close collaboration with lower organizational levels to enable successful implementation of marketing strategies.

A couple of the interviewed pointed out the importance of a shift in staff’s mentality about the ability to have a customer perspective. The opinion was that this perspective traditionally is non-existent and that a very few percent of the personal had a marketing willingness and ability.

The key marketing strategies pointed out by the interviewed was:

- Word-of-mouth marketing (by doing a good job, the word will spread)

- Marketing through individual professionals personal networks; e.g. doctors lecturing and trying to spread the word about UUH excellence.

- Agents; international sales through agents with local presence.
- Web marketing. A need for improved information about UUH services, especially in regard of certain diagnosis’s, was pointed out. A need for search-engine-optimization was also mentioned.

- A need for several different marketing strategies; e.g. some services can be marketed as service-packages (such as a specific surgery technique) and some areas were considered best marketed as ”centers of excellence”

**Regarding accounting**

The majority of the interviewed was convinced that UUH lacked one or more of key components necessary to reliably calculate the costs, setting the price, submit a correctly calculated offer or, consequently, bill the customer. Major flaws in the existence, use or implementation of administrative tools necessary to perform these tasks were pointed out.

One was convinced that they knew what they billed, others pointed out how hard it was to penetrate the basis for the calculation, making the economic results/profit of a sold service or offered service price impossible to verify. Mentioned was, for example, the fact that when one organizational unit consummates resources from another organizational unit, the customer’s usually won’t get billed for the related increase in cost. Another example was that some customers
receive price-discounts that affect the profit-margin in a very unpredictable way.

Mentioned was also the fact that UUH, due to deficiencies in the computer systems, for a prolonged period of time hasn’t been able to extract production data from registered patient procedures. The lack of reliable, consistent routines, possible to validate regarding the registration of procedures was further pointed out as a deficiency. These routines were mentioned to be non-existent.

A majority expressed the opinion that the tools and/or the competence to correctly calculate the profit margin of individual services was non-existent.

**Regarding incentives**

The interviewed all agreed that UUH didn’t use economic incentives in any form for any individuals in the organization. The reason for this got various explanations. Political reasons was mentioned, economic incentives was mentioned not to be “politically correct”. “Mental blocks” and “tradition” of not emphasizing individual performance was mentioned. One referred to practical reasons such as the problem with correctly calculating the productivity or economic result, therefore making it hard to reward individuals based on such data. The risk of general “Swedish traditional jealousy” was also mentioned as a barrier to overcome if implementing systems for rewarding individuals.
Two interviewed pointed out that the performance of heads of different departments was not measured in regard to production measures or economic result, or specifically the absence of individual consequences for poor performance in regard to these measurements.

Most agreed on the necessity of rewarding profitable departments, but the opinions varied of the best way to do this. There was also very various opinions if there actually existed such systems today. The budget systems was said to have its tradition from the tax-financed, plan-based economic system, therefore mechanisms for rewarding productivity or profitability was deemed unclear.

Pointed out by the majority of the interviewed was that the strongest incentive implemented and used today, was the threat of budget cut-backs to departments that do not perform economically.

Though, most of the interviewed expressed that positive economic incentives to individuals and department probably would result in higher productivity and increased sales. More than one of the interviewed had examples of key individuals asking the question “What's in it for me?” thus meaning economically. Examples were also given of other individuals that had chosen not to accept additional patients or additional work when they got the answer “nothing”.
Legislation and regulation in regard to marketing management

All the interviewed was very aware of the illegality of accepting payment from Swedish individuals outside the tax-based financing system. Though, marketing services to individuals to attract patients within this system was deemed legally ok (though comments were made about this being “politically incorrect”).

When discussion the question of legality of marketing (and selling) services to other county councils, organizations and non-Swedish citizens the interviewed had a few different opinions. Opinions about a “grey area” of legality were expressed. In this regard, referrals was made to legal allowance of selling “temporary excessive capacity” but an uncertainty was expressed if this reasoning could be applied to UUHs systematic and lasting marketing of services to neighboring counties and non-Swedish citizens.

One expressed that to be legal; UUH had to interpret the “general purpose” or “spirit” of the laws, rather than reading the laws literately. The legality was also considered easier to defend if a legal audit was aimed at the whole organization and more difficult to defend if individual markets or services were audited.

One expressed that there was a risk of being successful in the marketing of services, as this person judged the risk of being accused of illegality was higher if UUH successfully attracted customers in competition with privately owned health care providers.
The legal ban of adding a profit margin to the prices was mentioned, but opinions varied if this actually had any practical implications. Opinions was expressed that as UUH defines what they considered the production cost to be, pricing can include a profit margin without risk of getting any penalty regarding this legal restriction.

Ownership

Opinions varied about the strengths and weaknesses of being a public institution in opposite to a commercial company when marketing health care services.

Most of the interviewed pointed out different barriers with the current ownership that were hard to overcome. Those included the above reviewed questions of legal/regulatory complications.

A majority pointed out different problems associated with being a public, politically governed institution. Mental limitations or immaturity in the political government of health care services in regard to marketing and sales as concepts was referred to. The following examples were mentioned;

- Several problems associated with investing in potentially profitable markets. One example that was mentioned that that potentially profitable marketing of cosmetic procedures, was deemed politically incorrect.
- Political problems with cutting back or close dysfunctional departments or internal services.

- An intrinsic slowness in the system, preventing the organization to react on rapid changes on the market or business opportunities.

A few advantages of being a politically governed public institution were also mentioned;

- The strength of the brand was mentioned to be judged as connected to a long tradition of public financing.

- The close cooperation with research institutions was mentioned as dependent of the ownership.

**Key issues stressed by the interviewed**

When given the opportunity, the following key issues were stressed by one or more of the interviewed;

- The need of a dedicated marketing department, the need of recruiting marketing professionals and the need of an increased marketing budget.

- The need for proactive economic incentives, recognizing individual productivity and profitability.

- The need of directing the efforts towards specific areas of certain expertise, essential the need for concentrating efforts on niche markets.
7.2 Results from survey to department-heads

The survey was sent to approximately 68 department-heads. Exact number of survey recipients is not known as the survey was sent through two administrative steps. The initial deadline for answer was set to 19\textsuperscript{th} of January 2009. Due to low response rate, a reminder was issued. Still, at the 26\textsuperscript{th} of February, only 34 department heads had answered (50 % response rate). Due to the qualitative nature of the survey, no reliable statistics are possible to extract from the answers, but still, to be able to analyze the quality of the material some compliance-frequencies are listed. A compilation of the answers with comments of the quality of the material is reported below.

\textit{Regarding question: ”What type of health care services is your clinic currently marketing to neighboring counties and/or sales outside Sweden? Preferred form of answer; List treatments/diagnosis and their respective sales volume in numbers and monetary value.”}

The answers varied in quality. Only 15 of the department-heads (about half of the responders) actually answered the question. Five answered partly to the question and the rest (about 14) did not answer at all to the question or answered in an incomprehensible way. For example some chose to answer yes/no to this question. Some listed a few services but chose to ignore to answer volumes and monetary value of the current sales. The answers are not validated in comparison to the budgeted (or billed) values of the reported results in the survey.
Regarding question: "In your opinion, what is the potential for increased sales regarding each listed treatment/diagnosis? Report the increase/decrease in percentage (%) for each listed treatment/diagnosis. “

Here, the answers also were of very variable quality. Most of the persons that had answered correctly in the preceding question, also correctly reported their opinion of potential increase/decrease in percentage of the above reported values. Though, a majority of the responders chose to ignore this question or reported a percentage that was unable to relate to current sales. As these persons had ignored to relate to current sales, their reported percentage lacks validity and credibility. Only one person reported negative percentages (decreases) in the survey.

Regarding question: "In your opinion, are increased resources (personnel, economic etc) necessary to achieve the above stated potential in increased sales or is the increased sale possible to achieve with current available resources? If the answer is yes, list those necessary resources. ”

Most of the responders that had responded correctly in the previous question also provided an answer to this question. About half of the listed potential increase was deemed to achieve without additional resources. The resources listed to achieve increased sales varied from demand of additional nurses and physicians, to more complex demands such as “reorganization” or “a jet plane”.
Notably, some of the responders that hadn’t listed any potential in increased sales, still reported a need for more resources.

**Regarding question: "Describe current marketing activities aimed at neighboring counties and/or customers outside Sweden."**

Just a few responders answered this question with an actual attempt to deceptively answer the question. A common answer was the word “None” and several others just ignored reporting any activities. One answered with an attached excuse; “none, due to lack of time”.

Most of the responders that actually responded, responded only with a list of a few words without describing the activities further. Examples were “courses” or “regional meetings”, “pain brochure”. A few mentioned “web page” without further description.

Only a few was specific and understandable in the description of the activities, for example; “participation in customer meeting, a meeting resulting in a continued service provider agreement with UUH” and “visits to each satellite-lab each week, resulting in education of colleagues in the region and resulting in a continuous flow of admitted patients from the region”. A few other similar specific descriptions were reported.

**Regarding question: ”Can you identify new areas of potential sales? If yes, please describe those.”**

Nine (9) of the responding heads of departments have chosen to answer this question. Of those, there were examples of very
thin/insufficient descriptions. One example was that only the name of a common diagnosis was mentioned as an area of potential sales, but the description of what to do with these patients (the service offer) or why this was considered an area of potential sales was missing.

**Regarding question: “Roughly, what resources are necessary to really start-up and market these new services? Make a rough estimation of resource demands and projected sales volumes.”**

Of the nine answers to the preceding question, three had chosen not to answer this question and only two (2) had made a rough estimation of projected sales volumes.

### 7.3 Results from internal documents and internal material review

Amongst the massive amount of material reviewed, a few sources that are essential for the analysis were chosen. To clearly illustrate the current income-sources for UUH, economic data was extracted from annual reports and visualized in the pi-chart below; [Akademiska sjukhuset, 2008] 1

The annual report provided limited information about the market / customer perspective. Only about one (1) of a total of 67 pages in the annual report could be directly related to marketing performance. This information was extracted and reported in Appendix III. The goal concerning national and regional care was formulated as: “The revenues from sold national and regional care shall, price
compensation excluded, be at a minimum of the 2007 level 2008.” The result was; “The goal is accomplished.” The goal regarding international care, was formulated as; “Prerequisites regarding the development of Uppsala Care within operational areas where capacity is available shall be clarified during 2008. A report shall be presented during 2008 concerning the development of Uppsala Care.” The result was; “The goal is accomplished.” [Akademiska sjukhuset, 2008, p 15].

Distribution of revenues, UUH 2008, Total revenue approx. 6 billion SEK

1. Patient charges (approx 75 million SEK)
2. Revenues from services sold to other county councils (approx 1.6 Billion SEK) including revenues from international patients (Approx 40 million SEK)
3. Other revenues (Approx 700 million SEK)
4. Cost of taxation through Uppsala county council (Approx 4 Billion SEK)
[Source: UUH Annual report 2008]

In the external auditor’s report of Uppsala county council annual report 2008, the following comment was noted about UUH (translated from Swedish) [Landstinget Uppsala län, 2008, p17] **Goal:** “increase
the production per employee with 1% compared to 2007 within UUH according to previously developed model.” Auditor’s comment: “The goal cannot be audited”. A reference (an excuse?) was made to difficulties to extract data from UUH administrative systems.

From UUH operational plan 2009, materials regarding marketing was extracted, translated and reported in Appendix IV.

The 3\textsuperscript{rd} of Mars 2009, UUH management used SWOT as a method of discussing further strategies. The result was reported as follows;

<table>
<thead>
<tr>
<th><strong>Strengths</strong></th>
<th><strong>Weaknesses</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. UUH acts on a market exposed to competition and is used to this compared to other university hospitals. The business match, but not the organization – this can be developed.</td>
<td></td>
</tr>
<tr>
<td>2. People and competence</td>
<td>1. Territory-mindedness (narrow-minded)</td>
</tr>
<tr>
<td>3. Uppsala University (proximity and R&amp;D)</td>
<td>2. Strictly conservative, low propensity for change.</td>
</tr>
<tr>
<td>4. Improvement work is practiced</td>
<td>3. Unclear objectives (where do we want to reach long-term?)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Opportunities</strong></th>
<th><strong>Threats</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. New customers</td>
<td>1. The region</td>
</tr>
<tr>
<td>2. The national health care, collaboration with Stockholm</td>
<td>2. The demography</td>
</tr>
</tbody>
</table>

7\textsuperscript{th} April 2009, UUH management produced a draft for an operational plan for 2010. This draft was translated and reported in Appendix V.
7.4 Reflections regarding results from the data collection

As the investigators had to extract a small portion of data from a large material, there can always be criticism of the criteria for this selection. However, the material per se is deemed to have high validity as the original documents are available as requisition from UUH administration. Translations from Swedish to English may also have affected the validity in a negative way, although the investigators had previously been educated in translation validity of scientific English and also frequently discussed the translations in order to ensure the highest possible quality.

8. Analysis / Discussion

8.1 Regarding marketing management priority

Among the interviewed, there was a unanimous view that marketing activities currently is of very high importance and increasingly so in the years to come. The successes of the marketing efforts were generally rated as a matter of survival for the hospital with its current structure.

Despite the fact that a reminder was sent out in order to increase the survey response-rates, only 34/68 department-heads responded to it. This may partially be due to administrative errors, but this could also indicate a weak interest in sales of regional and international care.
As the majority of respondents either ignored questions related to marketing management priority, or did not relate their responses to current sales, their reported percentage lacks both validity and credibility. This is a strong indication that in contrast to the interviewed, most department-heads put marketing initiatives very low on their list of priorities.

One interpretation of this low response-rate may also be that the non-responders are negative to all aspects related to market-orientation and therefore actively ignores to answer. To speculate further, this low response-rate may be that they lacked the knowledge, facts or skills to even properly understand the questions. Another interpretation is the lack of incentives as they may know that if they chose to answer, this may lead to higher expectations or a higher workload. On the other hand, if they just ignore to answer, there will be no risk of consequences whatsoever for them personally.

As previously mentioned in the theoretical discussion, this discontent in marketing may also likely be due to lack of understanding of what it means to be marketing driven, and of what marketing unaided are able to achieve.

A crucial aspect to consider is also the influence of the organization’s culture. This includes the tradition of high levels of resistance to change (conservatism), a widespread resistance of being customer-oriented and behavioral norms of a non-customer/non-marketing/non-
sales-oriented attitude. These organizational culture norms are examples of variables that probably will make the transition from being non-market oriented to market-oriented even more complicated and not effortless.

8.2 Marketing organization and strategies

The results showed that despite the fact that UUH is an organization with a 6 billion SEK in turnover, it lacks a marketing department, seems to have no tradition of conducting market research and have only to a quite limited extent attempted to produce formalized marketing plans. There are also indications that the organization isn’t very customer focused.

Fundamental to the wide-spread definition of marketing according to PD Benett, is the importance of focusing on the consumer. Without consumer focus, there is a significant risk that customer satisfaction will be undermined, and this should be regarded as a problem, due to the fact that customer satisfaction is increasingly considered the key issue in health care. The results from this study indicated that the co-workers in the organization have a hard time identifying who the customer really is. The co-workers seems to have a tradition of viewing the individual patients as their customers but have no tradition of viewing the part who actually pays the bill as a valuable customer.
There are also indications that the customer perspective is more or less non-existent at UUH, and that a very small share of personnel have a marketing willingness and ability.

After review of all empirical data including the theoretical section, it becomes apparent that UUH uses a non-marketing determined planning procedure; even though there is vast support of the notion that many of the problems related with a non-marketing determined planning process can be solved through converting the planning process to a market-driven planning sequence.

The results of the SWOT-analysis suggest that the listed weaknesses narrow-mindedness and low propensity for change make the identified problems even more challenging when trying to come up with solutions. However, it is positive that there is an awareness of these limitations and difficulties, because this is a necessity and starting point to successfully initiate a process of change.

Regarding strategy formulation and implementation we have found that there are attempts of putting increased focus on this. For example; strategies are mentioned in the UUH operational plans, and even if there clearly is an identified need of development both with regard to the formulation and implementation of the strategies, it is positive to note these efforts since they at least provide a starting-point which will make the required change process a bit easier.
8.3 Regarding accounting

The results of the interviews showed that it seems that UUH has major flaws in tools or competence regarding accounting. The general opinion amongst the interviewed seemed to be the same conclusion regarding the lack of ability to correctly and reliably calculate the costs of individual services. Further, there seems to be some components missing in basic functions such as price calculations and/or billing including calculation for discounts. Therefore, the profit margin or the predicted or actual result seems to be unable to calculate.

As these basic accounting routines and -tools (price-, cost- and profit calculations) provides a foundation for a working market-economy driven organization, every attempt to evaluate the market performance of organizational units, department heads and individual co-workers are deemed to fail.

An interesting part was the fact that the county councils auditors pointed out the inability for UUH to deliver productivity-data. The analysis about this deficiency in productivity data extraction, weighted together with the flaws in the accounting-routines, would result in a conclusion that it must be impossible for the county council to evaluate if they are getting value for the tax-money put into the hospital. The county-council may actually be sponsoring hospital services to external customers, or perhaps Uppsala University’s research activities.
This may be one of the many plausible explanations for the department-heads low response-rate about the current sales volumes in numbers and monetary value. They may actually lack the accounting tools and/or the competence to answer the question.

Regarding the survey-results on the marketing-activities, it is possible to make the same mind-leap. One of the plausible factors in the survey results may therefore be able to relate to the accounting abilities. If the accounting-routines is lacking, the cost of the marketing activities may be hard to extract for a department-head and therefore the department-heads was unable to answer the question if they had any marketing activities.

8.4 Regarding incentives
This area is vital, and will most likely be quite challenging due to the fact that there practically are no incentive-systems implemented today, at least not in regard to hard data such as productivity, results or other economic performance. However, there is no way around the fact that these must be implemented in order to succeed with this process.

Following review/analysis, it seems evident that UUH do not use economic incentives in any form for any individuals in the organization, which definitely make this a prioritized area when it comes to need for improvements.
The low survey response-rate and the poor quality of responses most likely indicates that the lack of incentives in fact constitute a problem. Motivation seems low due to this, which ultimately leads to weak respondent interest, low response rates and low commitment.

8.5 Legislation and regulation in regard to marketing management

The legal and regulative framework has a high impact on marketing possibilities for health care services. UUH has to comply to these laws and principles or decide to take the big risk when eventually deciding to bend or break those laws.

The organization and its co-workers are very aware of the illegality of accepting payment from privately paying individuals. Though, it seems that this also has created a mental limitation regarding the possibilities of marketing directed at individuals to attract non-county inhabitants within the tax-financed system and thereby increasing the revenues.

This seems to be one of the few legal limitations that UUH complies with without reservation. No payment for health care services is accepted from individuals or organizations that want to buy a higher prioritized health care for individuals than the services every Swedish individual is entitled to, this according to the principle of equal treatment in the Local Government Act. Only one example of a possible legal breach in this matter was pointed out. The Swedish
Armed forces have managed to buy highly specialized health care services for some of its employees, employees who are Swedish citizens. [Akademiska sjukhuset, “Försvarsmakten…”, 2009].

All other possible conflicts to Swedish law and regulations regarding the marketing of services seem to be considered of lesser practical value. The legal principle about “cost-price” based pricing is considered bendable. Further, the legal allowance of selling “temporary excessive capacity” is considered no problem, even though approx 25% of UUH economy is dependent of external revenues. If 25% is considered as allowed level of excessive capacity has not been tried legally, especially not in regard to individual services such as jet-plane-transports or medical procedures marketed mainly at external customers.

8.6 Ownership

Regarding the impact the ownership has on the ability to be market-oriented: the results imply that the ownership provides additional constraints at the process of attempting an increased market-orientation of UUH. For example the intrinsic slowness to reactions in the marketplace and in the decision-process are claimed to be related to the political structure and this may give UUH a competitive disadvantage. The ownership is also deemed to be a limitation in the ability to invest in possible profitable ventures. The ownership may also be negative from a marketing perspective when budget-cutbacks are decided; very profitable departments or individuals that would be
complete immune to cutbacks in a market-based decision process, instead has the risk of cutbacks according to the traditional principle of “equally distribution of the burden”.

No data regarding the pros or cons of the current ownership could be directly extracted from the surveys. To make an analytic comment, the ownership, as being a tax-financed institution, probably had played a major role in the low priority of marketing activities showed in the surveys.

The claimed narrow-mindedness in UUH organization may be a result from the ownerships non-market perspective. Uppsala County Council is the main financier and they are also the part who has to cash up when high-risk projects or major customers fail UUH. Even if Uppsala County Council lacks in their ability to be market-oriented, they must be aware of the risk of annually losing up to 1,6 billion SEK if the current customers chose not to buy UUH services anymore.

In a strict market-organizational point of view, the county council and the individual patients are UUH largest group of customers.

8.7 Reflections regarding the analysis / discussion
Together; the theory, the interviews, the surveys and the documents, served as a stable foundation for the analysis.
The results from the interviews provided a lot of structure and ideas to build the main part of the analysis from. Several ideas and opinions from capable individuals within the organization were of high value. The promised confidentiality may have played a positive role in the quality of the information but at the same time the validation and analysis of the data is made a bit harder due to this promise.

The issues discussed in the analysis are mainly based on marketing theory and results from the interviews. The internal documents served mainly as a validation tool for the analysis, as these documents verified/strengthened many of the opinions and ideas extracted from the interviews.

The results from the surveys may not have produced that much valuable data per se, but still the lack of information and the inconsistencies in the answers have other values for the analysis. The author’s opinion is that the results of the survey provided a certain degree of validation of the analysis of what is lacking in UUH administration. Though, we still can’t verify if the cause mainly was due to low competence, low willingness to comply or deficiencies in the administrative systems.

9. Comments / Conclusions

9.1 Current health care marketing status at UUH
Marketing activities is most likely considered of very high importance, at least by upper management, which is a great starting
point. On the other hand, there are also factors indicating a weak interest and low prioritization of sales of regional and international care among department-heads who are the front line, which is likely to complicate attempts of transferring from a non market-driven to a market-driven organization.

UUH lacks a marketing department, as well as staff with formal marketing competence. Attempts at producing formalized marketing plans are quite limited. In addition, there is no tradition relating to market research or market analysis risking significant errors in prognosis-results, which may lead to unpredictable results-variations by hundreds of millions. The customer perspective seems to be more or less non-existent at UUH, and there are difficulties among staff when it comes to identifying the actual customer. It is not difficult to understand why there are limitations with regard to customer focus from a marketing perspective, when personnel don’t even know who the customer is.

There seem to be a low level of marketing willingness and ability, and there is an evident lack of market-orientation throughout the organization.

UUH is today managed through a non-marketing determined planning procedure. However, there are attempts of putting increased focus on marketing strategy formulation and implementation, even though there
is a clear need of development both with regard to the formulation and actual implementation of the strategies.

UUH seem to have major flaws in tools or competence regarding accounting. Basic accounting routines and tools are lacking (price-, cost- and profit calculations), which is a significant problem because they provide a necessary foundation for a functioning market-economy driven organization. Without the right tools and routines, there is no way to evaluate the market performance throughout the organization, which in reality means that success/failure with regard to providing value for money is more or less random, and also difficult to influence.

There are practically no incentive-systems implemented. UUH do not use economic incentives in any form, especially not incentives related to individual productivity or marketing performance. In addition, there are no sufficient and reliable follow-up systems for the delivery of results and productivity-data, which contribute to this “no incentive” perception.

The legal and regulative framework with a number of legal limitations has a high impact on marketing possibilities for health care services. This most likely also creates mental limitations with UUH personnel regarding the possibilities of marketing. The ownership structure provides additional constraints at the process of attempting an increased market-orientation of UUH.
In conclusion, there are in fact quite a few obstacles to overcome in order to enable the transition from a non market-driven organization to a market-driven one. The current, tradition-bound, organizational culture has to be forced to re-shape in order for implementation strategies to work. We believe that incentive-systems can provide a very valuable tool if this necessary transition is to be successful.

In addition, since politics has a great influence on the health care business, there is always the chance that some of the obstacles will be overcome simply by new regulations and when/if that time comes, it will be even more essential to be prepared.

In the following section we present our recommendations and suggestions for measures which we are convinced can be used as valuable support tools for performing the challenging transition that lie ahead for UUH and other Swedish hospitals working under similar conditions.

**9.2 A road map to market adapt Swedish health care: the steps that lead towards success**

Here an attempt is made to compress and present the more vital results into structured practical recommendations ready for employment. As the laws, the governance-structure and the services provided by other Swedish county-councils are basically the same; the recommendations would therefore be of use to many other public hospitals in Sweden.
These recommendations will most likely be applicable even though the data extracted mainly originate from the study of a specific Swedish hospital.

There are a number of main prerequisites to enable successful implementation of marketing strategies into an organization with evidently limited experience of thinking or acting in accordance with established marketing theory.

**Step 1) Creation of a common vision, mission and mindset in regard to marketing of services**

As the ownership and “political” aspect is considered a mental barrier to overcome in changing the mindset within the organization, this limitation is essential to eliminate.

To lay out the foundation for this; the creation of a document with formulations of a common vision, mission and mindset regarding marketing is of great importance. Besides the long-term visionary goals, the document has to be able to serve as a practical guide for the individual co-workers every-day situation, regardless of if the co-worker is a manager or a clinical practitioner.

This document should be focused on answering questions regarding the practical decisions every co-worker has to make. Examples of those questions are: Who is the customer? Is it approved and encouraged to promote services to individuals or am I supposed to
restrict the care? Am I supposed to restrict the care and costs to county-council inhabitants while at the same time expanding care to paying external customers? Will a high degree of revenue from non-Swedish individuals be considered a merit for me and for my department? Are my department’s or my own productivity valued as an asset or a financial burden? Will I be rewarded by engaging in administrative activities aimed at increasing revenue and satisfying paying customers or should I focus at research activities?

This document also has to be legally evaluated and deemed legal within the boundaries of Swedish and EU legislation. The document probably also has to be formally approved and firmly established within the county council political organization. That way, co-workers should not be able to be in doubt to what is and what is not politically correct and hence clear on what is and what is not encouraged in regard to marketing and sales.

Only then, the organization will be able to successfully remove existing doubts regarding “political correctness”, successfully change the mindset throughout the organization and to successfully implement marketing strategies.

**Step 2) Reorganization of the strategic planning from non-market determined to a market-based process**

The mental and practical leap from the current non-market determined planning process to a market-based process is the next necessary step.
If such a shift is successful, this will solve many of the current formulation and implementation problems of marketing or customer-focused strategies that are associated to the non-marketing determined planning process. The mindset will, or has to be, changed to make this shift possible.

The first decision that has to be made is that the hospital has to invest in enabling formalized marketing-research, preferably as a part of a marketing department. The second step that has to be taken is that the marketing-departments recommendations, based on marketing research and market estimates, has to have immediate and direct effect on the strategies, budgets and other decisions.

To be successful, the internal processes of the hospital at lower levels also have to implement the same planning-process. Basic market research tools and market-analysis models have to be available to department-heads in their decision making. The development of these practical tools and models will probably be one of the marketing-departments highest prioritized tasks.

**Step 3) Get the accounting and productivity-measurement systems and routines in perfect order**

As a foundation of a working market-based economy is to have the ability to correctly measure individual services, such systems and routines has to be implemented. Without that ability, any attempt to calculate profitability, setting prices or making a correctly priced
service offer to a customer will fail. Further, to measure single departments and individual’s marketing performance in the marketing-based planning process, systems and routines for the extraction and compilation of easily accessible and reliable productivity data has to be implemented.

If, from a marketing perspective, the county-council or the tax-payers are considered as customers, such systems also need to be in place to correctly evaluate if these customers are getting value for the annual funding. To further prove for the tax-payers that they are getting value for the money is to actively and boldly take part in existing productivity comparisons with other county-councils hospitals. Successful implementation and use of these systems and routines related to accounting are a prerequisite to be able to do that successfully.

This step is also necessary if any incentive-systems based on productivity or performance is to be implemented.

**Step 4) Implement incentive-systems based on marketing performance**

To ensure compliance with marketing goals throughout the organization and thereby consequently determine success or failure, the measurement of the outcome is not enough. Incentive-systems that are in concordance with the marketing goals have to be implemented at all levels.
Reward-systems must be in place that distinguish the value of a customer orientation, and provides the entire organization with pressure to grasp and to respond to customer needs.

The staff must be devoted regarding improving the organization in taking positive marketing initiatives. This can most likely not be achieved without the support of various incentive-systems.

As a result of this study, the logical start with the implementation of incentive-systems at UUH is initiating formal performance-evaluation of the department-heads. If the department-heads are measured by marketing performance and productivity with attached incentive-systems, this will most likely be of great importance for the implementation of marketing strategies and performance goals.

9.3 Final reflection and suggestions for future studies

It is important to remember that health care most likely constitute its own area of research which also is specific for Sweden. It is not enough to use existing marketing theory literature/research and simply apply it to health care. This due to the fact that health care is a unique area with unique prerequisites which must be taken into consideration.

The ideological factor of defining health care services from a marketing-theoretical framework may be opposed, but this case study clearly shows that UUH acts as a player at a competitive marketplace;
a marketplace where competitive performance is crucial for daily activities and it also greatly influence strategic planning.

This presents a strong need of further marketing research with regard to the health care sector, the Swedish in particular. A suggestion for future research is to try and find out just how to enable implementation of a marketing-orientation in an organization which never had one.

Another suggestion for further research could be directed at how economic incentive systems and other means of co-worker stimulation influence the production of health care services.

We hope that this project will in some way contribute to the development of Swedish health care, and that healthcare managers and possibly concerned politicians will assimilate the key messages of this project.

“When the winds of change are blowing, some build wind shelters, and others build windmills.”

Chinese proverb

Lastly, it is going to be quite interesting to follow the development of UUH and other Swedish hospitals working under similar conditions. Some day in the future it will be possible to determine if they chose to build wind shelters or if they chose to build windmills. In the end, this is in fact a choice, and it is their own.
ACKNOWLEDGEMENTS

First, we would like to issue a big thank you to our supervisor, dr Lars Ekstrand, who provided us with valuable guidance and advice through the process. We would also like to thank all cooperative personnel at UUH, especially the interviewed that generously gave us their valuable time.

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FIGURES AND TABLES (LIST OF REFERENCES)

Figure 1; Source: Uppsala University Hospital (UUH), 2009, organizational web site, http://www.akademiska.se/templates/page___41314.aspx, fetched and last checked, 2009-04-10

Figure 2, Source: The Swedish Institute, 2007, “Swedish Health Care, Fact Sheet FS 76 z”, Published by the Swedish Institute, January 2007

APPENDIX I - INTERVIEW QUESTIONS

Note: Translated to Swedish. Swedish version used in interview situation.

Regarding marketing management priority;
- How important do you consider the area of marketing and sales is of UUHs health care services today, in 5 years and in 10 years?

Marketing organization;
- Do you consider the market management at UUH to be organized in a satisfying manner?
- Do you favor a centralized marketing organization or do you prefer a decentralized marketing organization?
- Do you consider UUHs current marketing competence, organization and efforts to be adequate or is there room for improvement?
- Please roughly describe what UUHs most important marketing strategies should be.
- Would you consider economic incentives to key individuals or organizational units (such as bonuses or result-based salaries) as a mean to achieve increased sales?
Accounting;
- Do you consider that UUH has routines and systems to provide reliable calculations of costs, pricing and results of individual products/services?
- Do you have knowledge of the estimated results of current sales?
- Would you consider investing in a high-risk project to possibly gain profit?

Legislation and regulation in regard to marketing management;
- Do you consider UUHs health care marketing activities to be consistent with regulations and regulations applicable to a publicly owned health care organization?

Ownership;
- In your opinion, what are the most important strengths and weaknesses by being a public institution when you are marketing health care services?

Spontaneous comments;
- Feel free to explore any key opinions about UUH health care marketing.
APPENDIX II – SURVEY QUESTIONS

Note: Original language Swedish, translated to English.

1 – What type of health care services are your clinic currently marketing to neighboring counties and/or sales outside Sweden?
Preferred form of answer; List treatments/diagnosis and their respective sales volume in numbers and monetary value.

2 – In your opinion, what is the potential for increased sales regarding each listed treatment/diagnosis?

3 – In your opinion, are increased resources (personnel, economic etc.) necessary to achieve the above stated potential in increased sales or is the increased sales possible to achieve with current available resources?

4 – Describe current marketing activities aimed at neighboring counties and/or customers outside Sweden.

5 – Can you identify new areas of potential sales? If yes, please describe those.

6 – Roughly, what resources are necessary to really start-up and market these new services? Make a rough estimation of resource demands and projected sales volumes.

Note: Original language Swedish, translated to English.

**National and regional care**

**Mission/goal**
The revenues from sold national and regional care shall, exclusive of price compensation, be at a minimum of the 2007 level 2008. *Comparison of reports of sold care 2007 and 2008.*

**Comment**
The goal is accomplished.
The revenues from sold national and regional care increased by 6,4 % with regard to flexible prices and by 2,5 % for fixed prices. Sold care increased mostly from the regions Dalarna, Värmland and Örebro, while a slight decrease can be noted with regard to Gävleborg and Stockholm.

**International care**

**Mission/goal**
Prerequisites regarding the development of Uppsala Care within operational areas where capacity is available shall be clarified during
2008. *A report shall be presented during 2008 concerning the development of Uppsala Care.*

**Comment**
The goal is accomplished.
Our goal has been to increase the number of foreign patients and the turnover.
An investigation has been initiated regarding the development of Uppsala Care within fields of operations where there is available capacity. Surveys to all department heads have been sent out with the purpose of identifying "products" which uphold international standard and shall later on also be marketed internationally.
Uppsala Care however, has a sense of what is practicable with regard to international sales and has initiated marketing of these specific products on a small scale.
Uppsala Care has focused during the year on receiving quick access to resources since a major part of the success is dependent on good logistics. An example is that Uppsala Care from January first 2009 will have access to surgical resources two days per week.
A new home page has been produced and is available from February third, where response to patient requests is guaranteed within 72 hours. During 2008 an increase of care sold to foreign patients has taken place. During 2008 426 patients where billed from 60 countries compared to 395 patients from 59 countries 2007.
APPENDIX IV – MARKETING DATA EXTRACTED FROM UUH OPERATIONAL PLAN FOR 2009

Note: Original language Swedish, translated to English.

Current status and goals / Market / Our customers

The Uppsala county council

UUH is responsible for the care and health of county residents in accordance with the health and health care board’s mission.

External customers

The hospitals also have agreements with other county councils, and at present we have agreements with Dalarna, Gävleborg, Värmland and Örebro. In collaboration with the university hospital in Örebro, we also have a common agreement with Sörmland and Västmanland. Other important customers are Norrlands county councils regional association (including Norrbottens, Västerbottens, Västernorrlands and Jämtlands county councils), and Ålands health care. Through generous applications of the national agreements regarding ”rules of electiveness” there is also a significant amount of patients coming from Stockholm to Uppsala, but also from Uppsala to Stockholm.

Sold care for 2007 amounted to 1417 Mkr for the nine biggest customers.

In addition to this was sold care to the rest of the country and care sold to international customers for 68 resp. 36 Mkr.
Partnership
The hospitals agreement concerning highly specialized care in addition to the care agreement with the health and health care board does not only regulate pure purchases of care. They also create a platform for partnership, such as common work and development of care chains, health care programs, health-inducing care, competence support and training with mutual benefit. The buyers within Uppsala as well as the region will be provided with continually increased involvement and influence regarding the UUH-activities. Even when it comes to the UUH compensation for performed care there is a “division of risk system” in place which is beneficial to both parties since it lowers the economic effects of large volume changes. The partnership demands much of the concerned co-workers on different levels. They should be aware of these agreements and committed as well as contribute to this in a positive manner.

Brand and market position
A brand consists of both the name and the logotype, and in addition of the image created with a person when the brand is seen/heard. Freely translated, brand means confidence capital. UUH require a strong brand in order to continue to do what we are good at.

The market position express what we want others to think of us:

- UUH always provide the best treatment and the most interesting way of collaboration.
• UUH is the university hospital closest by, no matter the distance.

In order to strengthen our brand and market position all co-workers must act in accordance with these. Due to this, it is vital to continue dialogue about the meaning of our core values humility, skill-fullness and long-term.

**Market strategy**

*UUH shall offer partnership*

The hospital will continue to develop co-operation with other county councils regarding care, research and education.

*UUH shall identify new services and treatment methods*

The hospital will continue to map and develop new forms of providing care to be able to offer these to partners and the rest of the market.

**Alignment goals**

• UUH is the main supplier of hospital-bound outpatient and inpatient care- in addition to highly specialized care within the C-county and within the region.

• Develop and formalize the partnership within the region.

• The sales of care to other actors within and outside of the country will be increased.

• UUH is one of three leading university hospitals with regard to research, education and development.
## APPENDIX V – UUH OPERATIONAL PLAN FOR 2010 (DRAFT PRODUCED BY UUH MANAGEMENT ON 7 APRIL 2009)

*Note: Original language Swedish, translated to English.*

<table>
<thead>
<tr>
<th>Our mission</th>
<th>Our vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>To offer health care and highly specialized health care within the county of Uppsala in accordance with the care agreement with an economy in balance.</td>
<td>UUH is the university hospital closest by, no matter the distance.</td>
</tr>
<tr>
<td>To satisfy the need of foremost highly specialized medical care of patients from county councils where an official agreement have been made.</td>
<td>We are innovative in all areas, provide the best treatment and offer the most interesting forms of collaboration.</td>
</tr>
<tr>
<td>To collaborate with the University and carry out research, development and education.</td>
<td>Sales of care to other actors within and outside of the country shall be increased.</td>
</tr>
<tr>
<td>To develop a health-inducing health care in accordance with the county councils public health plan.</td>
<td>The county council shall apply to the National Board of Health and Welfare for accreditation to perform highly specialized care within areas of sufficient competence.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our core values</th>
<th>Our strategies</th>
</tr>
</thead>
</table>
| Humility: we treat people professionally and with commitment, respect and personal interest. | **Suggestions:**  
We work in accordance with Lean. |
<p>| Skill: our competence and work ethic – shall be reflected in our services: the medical knowledge, the care, the research and training. | We strengthen our market position. |
| Long-term: our way of working: planned cooperation instead of event-steered work, partnership instead of individual efforts. Exchange, follow-up and enduring presence is natural to us. | We prioritize, are focused, clear and implement. |
| Each co-worker feels important and takes responsibility for and contributes to our result. | Each co-worker feels important and takes responsibility for and contributes to our result. |
| We keep an optimal staffing. | We keep an optimal staffing. |</p>
<table>
<thead>
<tr>
<th>Perspective</th>
<th>Market</th>
<th>Good care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alignment goals</td>
<td>We are the main provider of highly specialized care within the region. We are Sweden’s largest sellers of national- and international care. We have developed and formalized partnerships with all customers.</td>
<td>We offer the: Best quality Highest level of patient safety Highest availability and Lowest prevalence of infections among the Swedish university hospitals.</td>
</tr>
<tr>
<td>2010 goals</td>
<td>We have sold at least the same amount of care to external customers. We have, with regard to C-county-inhabitants, not purchased more hospital care outside of the county council. We have located at least one new market.</td>
<td>The prevalence of: care-related infections fall-related injuries pressure sores and maluse of drugs have decreased. Our results from open comparisons are improved and is above the national average We fulfill the “care-warranty”. The Quality-manual is used in all departments.</td>
</tr>
<tr>
<td>R&amp;D</td>
<td>Co-workers</td>
<td>Economy</td>
</tr>
<tr>
<td>--------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>We are one of three leading university hospitals with regard to R&amp;D.</td>
<td>We are a modern and stimulating workplace with: Competent, committed</td>
<td>The hospital provides correct care and has a stable economy at the same</td>
</tr>
<tr>
<td>The research is conducted on the basis of department/subject and</td>
<td>Innovative, health aware co-workers who has fun at work and the patients best</td>
<td>time with room for development and innovation.</td>
</tr>
<tr>
<td>not the profession.</td>
<td>interest at heart.</td>
<td></td>
</tr>
<tr>
<td>We conduct world leading R&amp;D within our national health care specialties.</td>
<td>Our managers provide a clear leadership.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Our staffing is flexible and equitable and is based on co-workers with the right competence.</td>
<td></td>
</tr>
</tbody>
</table>

The strategic plan for the hospitals R&D is well-anchored and known.

The number of publications per doctor/year has increased.

The number of head supervisors (for nurses) who has a master's degree has increased.

The number of associate professors has increased.

All divisions have action plans for short- and long term staffing.

The Co-worker index has increased.

The involvement has increased.

Sick-leave is under 32%.

At least 90% of the front line managers have participated in our manager-training.

We have a balanced economy.

We are cost-effective and decrease waist.

We can adjust our costs after decreased inflow of national- and regional care.

Our co-workers are cost-aware.