THE CLINICAL MANAGEMENT - THE SANITARY MARKETING CONVERGENCE AND COMPLEMENTARITY

Bitca Tiberiu Alexandru
National School of Politic and Administrative Science, Strada Uranus nr 5-7, Bl. A7, Ap.7, sector 5, Bucuresti, tiberiubatca@gmail.com, 021.410.72.74.
Ioanăş Corina
The Academy of Economic Studies Bucharest, The Faculty of Accounting, Informatics and Management Control Bucharest, Strada Piata Romana nr 6, Sector 1, Bucuresti, corina_ioanas@yahoo.com, 0723.425.592

Initially appeared in the context of increased preoccupations for leading the organization as best as possible, the Marketing-management has later imposed itself as a management of the request, concretized in the formulation of marketing objectives and strategies for all the problems concerning performance achievement. In what these objectives are concerned, the sanitary organization differs from the other domains, since it doesn't enjoy the freedom of establishing the prices and choosing the consumers according to their payment capacity, this difference leading to conflicts, because, while doctors make decisions in the best interest of the patient, the management is mainly concerned with the cost and efficiency of the performed activities. Having as a starting point a literature review, the present paper sets to highlight the main difficulties encountered in the implementation of this frontier discipline in the medical field.

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JEL classification: I18, M31, P36

1. Management versus sanitary management

At its origin, the word **management** comes from the Latin "*manus*", which means "*to hold a horse or a carriage with the help of the reins*", and throughout the time, several other definitions have been given to management[320]:
- **Henry Fayol**: *to foresee and plan, to organize, to lead, to coordinate and control*;
- **Hersey** and **Blanchard**: *working with individuals or groups in order to accomplish some organizational objectives*;
- **H Brech**: *assuming the responsibility for deciding, planning and regulating the activities of some individuals working for a common purpose, in order for the correct result to be efficient and economic*. Synthesizing the above mentioned assessments, we can state that, in a broader sense, the word **management** represents *an ensemble of activities coordinated in view of directing and controlling an organization.*

The play upon words **management – health** has been conceptually delimited by **A. V. Ciurea**, **V. Gh. Ciubotaru** and **E. Avram** in the paper *The development of Management in Health Organizations*, University Publishing House, Bucharest, 2006, making a **clear difference between:**

The management of health systems, which is concerned with planning and accomplishing, in good conditions, the division of responsibilities, of the coordination and regulation mechanisms, the distribution of decisional power, of resource management, in the **regulating and deciding institutions of the health system.**

The management of health structures comprises all the management activities and operations of the **medico-sanitary practice and of the personnel management of each health unit.**

The health management refers to all the management activities that are accomplished and which can be achieved in the system and subsystems of the health department; it includes **the economic management, the organizational management and the human resources management,** being applied within and between the organizations from the social sector of health-care.

Sanitary management deals, mostly, with those managerial operations that **strictly regard the activities, actions, the medico-sanitary tasks,** operating with that knowledge and practice related to the norms and specific actions of the health-care units.

If concepts such as economic management, organizational or human resources management are considered to be somehow obsolete, being treated for several decades in the specialty literature, the greatest challenge of our times seems to be **the quality management.**

Even though the dictionaries provide a plentitude of definitions for the term of **quality,** neither of them has been universally accepted. Strictly related to the concept of **product,** the term quality can be approached in two ways[321]: "*the quality is rendered by those characteristics of the products that meet the needs of the customers; the better these characteristics, the higher the quality, and quality implies lack of deficiencies; the lesser the deficiencies, the better the quality*".

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320 Petru Armean, Management sanitar noţiuni fundamentale de sănătate publică, Editura CNI Coresi S.A., Bucureşti, 2004.
321 Petru Armean, Managementul calităţii serviciilor de sănătate, CNI Coresi S.A. Publishing House, Bucharest, 2004.

Some authors[322] offer a more pragmatic definition of **quality, adapted to the medical activity**: "*The achievement of the client's durable satisfaction, primarily of the patient's, at the best cost. Quality is nothing else but the satisfaction of the client, the consistency between what they expect and what they get. On the one hand, we have the patient, with a certain number of needs, of expectations and demands, and on the other hand we have the care, with a certain number of characteristics and attributes. So: quality means how to satisfy your patient? How to proceed so as the attributes of the health-care should correspond to the expectations of the patient?*".

2. Marketing versus sanitary marketing

There are more definitions given to the notion of "**marketing"**, the most complete being this one[323]: *Marketing represent the process of planning and executing the concept of establishing the price, of promoting and distributing idea, goods and services, in order to create fluxes that should satisfy the individual and corporate objectives.*

The American professor **Philip Kotler**, also known as "**the father of modern marketing**" proposed, in **1992** the following definition[324]: *Marketing represents the economic and social mechanism by the means of which individuals and groups obtain what they need and desire through producing and exchanging goods and services.*

Therefore, the dynamic force that stands at the base of the marketing activity is the human need. To meet this need, we must come prepared, equipped with the knowledge that should help us know **what, when, how and to whom we must offer in the exchange process.**

The marketing vision combines the adoption at the level of the entire organization of the marketing philosophy with the functional aptitudes of satisfying the consumers' needs, in such a way that the *previously known market is the one that determines the characteristics of the product and service and the manner of commercialization, and the producer creates only the products and services the customer desires.*

This way, the **objective of the marketing activity** is achieved, objective about which the great American specialist **Peter Druker** says that "*it is not the one of making the sale redundant. The purpose is getting to know and understand the client so well that the product or service should match its needs… to sell itself*"[325]. This vision has gradually gained ground, along with the transition from the concept of marketing, which represented only the sale activities, the physical distribution and advertising, to the **marketing managerial orientation, expressed through the marketing mix.**

The key elements of the marketing activity are: *the consumers, who must be the focus of attention for the activity of the enterprise, with their needs and desires; the profit, which is the final purpose accomplished through the satisfaction of consumers' needs; the marketing organizing that enables the making of decisions according to the demand.*

Therefore, accepting **the marketing vision** can be transposed in the following imperatives: *to discover the needs of the consumer and to fulfill them; to produce only what can be consumed, instead of trying to sell what is produces; to love the consumer, and not the product; to profitably satisfy the needs of the consumer.*

The universality of marketing – a feature of modern marketing theory and practice – has asserted itself over the last few decades, when the fundamental structural changes taking place in the configuration of the economic, social and political environment created new opportunities that confer new dimensions to the content and functions of marketing, new perspectives and orientations. A retrospective of marketing evolution reveals, over the last few decades, a permanent tendency of diversification and specialization, in various rhythms and proportions, determined by the particular conditions of each domain, which has led to the outline of a marketing typology.

The delineation of marketing types can be made on according to certain criteria, which abound in the specialty literature, such as: *the objective of the activity, the level of organization, the territorial area, etc.*

The objective of the activity enables the classification in:

1. The marketing in social or non-lucrative domain, in which there are no products or services produced or performed for commercial use, but in which we deal with ideas meant to trigger social behaviors pointing towards a social legitimate cause.

2. The marketing in the economic domain, which refers to the lucrative department, in which goods and services are produced in order to satisfy the demands of the consumer, but at the same time in order to bring profit to the producer. Due to the profit or to the nature of the economic activity, the economic marketing has split into:

a. Consumer goods marketing – the consumer goods is the field where marketing has originated from, now having the widest applicability.

b. Productive use goods marketing (of the means of production or investments goods), mainly destined for industrial consumption, meaning industrial marketing, employed on a broader scale.

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322 Costică Opincaru, Emanuel Mugurel Gălețscu, Emilian Imbri, Managementul calității serviciilor în unitățile sanitare, CNI Coresi S.A. Publishing House, Bucharest, 2004.

323 Nepveu – Nivelle, Le marketing industrie, les Editions d'Organisation, Paris 1972.

324 Kotler Ph, Principles of marketing, Third Edition, 1989, pag. 757.

325 Kotler Ph., Armstrong G, Principles of Marketing 5th, Prentice Hall Englewod Cliffs, New Jersey 1991 pag. 497.

3. Services marketing – has as a domain the tertiary sector, characterized by heterogeneity, intangibility and inseparability of the provider, fact which has imposed some specific methods and techniques, and, along with the development of both tertiary sector and marketing, led to the delineation of separate areas, that are now at their peak: **medical services marketing, financial marketing, transport marketing.**

Bearing in mind the previous classification, we further present the main differences between the business marketing, the social marketing and the medical marketing.

Table 1: Differences between the business marketing and the social marketing[326]:

Business marketing	Social marketing
It is applied to goods and services, and less to ideas.	It is applied to persons, places, ideas, goods and services
The changes are of a financial nature	The changes are not of a financial nature.
The purpose of the activity is profit increase.	The purpose of the activity is more complex, not being able to be strictly measured in financial terms.
The benefits are correlated with the payments made by the consumer.	The benefits are not correlated with the payments made by the consumer.
The enterprises address only to profitable market sectors.	The non-profit organizations regularly address to groups with a rather reduced buying power.
The market of the enterprise has a sole component: the relationship with the client.	The market of social organizations has two components: the relationship with the client and with the financing system, between which there are antagonistic liaisons.

Table 2: Differences between the business marketing and the medical services marketing:

Business marketing	Medical marketing
The purpose is **profit increase,** either through the improvement of the product's features, or through cost reduction, in order to maintain the supremacy on the market.	**The purpose is the increase of the quality of the provided services,** in order to **better serve the patients and** in the end, **the improvement of the population's state of health.**
The main objective is having a **price policy** that should **maximize the profit (**the rapport between incomes and costs**)**	**The main objective is offering qualitative health services,** ensuring the progress from the perspective of the provided treatments, of the employed medical equipments and of the well trained, patient-oriented medical personnel.
The purpose is of bringing the product in contact with potential consumers.	**The purpose is making the medical service accessible to all patients.**
The purpose is that, through the means of advertising, **to modify the demand of the consumer, in the benefit of the promoted products.**	**The purpose is to adapt the medical service to the patients' expectancies and to familiarize them with it,** taking into account the **asymmetric information of the patients,** due to the different social environments they emerge from.

3. Sanitary management-marketing. Difficulties and controversies

Henri Guitton, to whom we owe the development of **health economy** in France, considered that that was a new discipline, ascertaining that "the principles that gave birth to the economic science are not perfectly applicable to the health related issues." Indeed, the concepts and paradigms employed for the description, explanation and organization of all the activities of a human collectivity, related with the production and exchange of material goods, seem not to be adapted to the goods and services that regard life itself.

The first difficulty the economists specialized in health-care problems are confronted with, concerns ***the definition and measurement of the quality of the product resulted from the activities of the professionals in this field (producers).*** Undeniably, even though, in theory, the means used by these professionals are relatively easy to determine, the definition of the obtained result is of an unquestionable difficulty. What the consumers that resort to the services of one of these producers desire to obtain is: to recover the lost health, to maintain their health or to improve their health.

The second difficulty encountered by the health economists is the one of ***the information the agents have about themselves and about the results they hope to attain by addressing themselves to a professional in the health department.*** The patient doesn't generally have more than minimum information regarding the state of his or her health and its evolution; therefore, the patients resort to the professional in order to obtain first of all a piece of information about this state: a diagnosis. Irrespective of the qualities of this expert, the answer cannot be

326 After Violeta Rădulescu, Marketingul serviciilor de sănătate, Uranus Publishing House, Bucharest, 2008.

formulated in anything more than probability terms. The patient will then want to obtain information about the various means and technical processes that could allow him or her to either maintain this state or improve it. Again, the results of these means and processes can be described only in probability terms. The context in which the patient must exercise his preferences over certain distributions of probability determines him to generally give the producer the freedom to choose the treatment strategy. The client assigns the producer to decide for him. We are, thus, very far from the common hypotheses of neoclassic economy, because the independence of the demand and of the offer is no longer ensured.

A third problem emerges from ***the specific character of the "health" good and of its social representations.*** In our modern societies, "the right to health for all" is a undeniable value, resulting from a continuous process of social negotiation concerning the definition of the health needs that must be satisfied. The concept of need is imprecise, and since every need brings about another need, they risk becoming infinite. Consequently, the society engages to establish social justice and equity principles and then implement devices that should allow it to define the objectives of health, compatible with these principles.

A forth problem is represented by the evaluation, which is generally defined as a "demarche that consists in a judgment of value over a technique, a practice, program or policy, enacted in view of making a decision". The apparition of **medico-sanitary evaluation and analysis** as a new discipline that adds the economic criteria to the medical ones, is regarded with a certain withholding, even reticently we might say, by the world of health care. Therefore, questions such as: "*How should financial criteria be introduced in such an essential area as the health-care domain? Wouldn't it be appalling to refuse certain medical care due to economic considerations? Is it in the doctor's power who has the liberty to prescribe treatment, to take into consideration only the well being of the patient, providing him the best medical treatment?"* determine *the medical institution not to take into consideration the economic consequences of their decisions.*

The health-care economist, however, will fill in this simple instrument with: *a theoretical efficacy evaluation of the health programs* that quantify the therapeutic benefits for the patient in a situation defines as ideal; *a practical evaluation of the health programs,* which has as a goal the integration of the patients' adhesion to therapeutic benefice; and *an evaluation of the health programs availability* that concerns the selection of the studies population.

Controversies related to the economic evaluation – medical evaluation rapport take into account:

I. The perspectives of evaluation. The evaluations can be performed from the point of view of several actors. So, we can concentrate *only on the patient and his or her family* (for instance: for the cost of *dialysis we can analyze the expected repercussions over the patient's entourage)*; further on, we can extend the perspective over the *health institution* (example: *what operations in the ambulatory can be performed in view of improving the budget of certain structures*); or over the *collectivity taken as a whole – the state.*

In either of these hypotheses we might place ourselves, the adopted angle must be indicated, since it influences the nature of the elements taken into account and the calculation of costs. Therefore, *the cost of a health program depending on the chosen perspective* can be defined as it follows:

a. From the point of view of the **social security system, the cost of the health program** equals the sum of the reimbursements of the expenses it triggers, its evaluation having as a starting point the nomenclature of the documents published by the health insurances.

b. The patient perceives the same cost through the prism of the honoraries and possible expenses related to the disease and treatments not reimbursed by the social insurances.

c. The medical institution evaluates the cost of a certain health program from the perspective of financial, material and human resource, necessary for its implementation.

d. From the viewpoint of the **employment institution,** the cost of a health program consists in the production losses related to the patient's work interruption.

e. Regarded from the **global perspective of the society,** this cost corresponds to the amount it accepts to pay for health, in the detriment of other budgetary domains, being evaluated through adding together the costs engendered by the previously enumerated programs.

II. Cost determination. From the standpoint of the sanitary institution, there are **three possible types of classifications of the hospital expenses: accounting classification,** which corresponds to the distinction between *direct-indirect expenses*; **medical classification,** which distinguish between *medical expenses, logistics expense and structure expenses;* **economic classification** sets in contradiction *variable costs – fixed costs.* As such, the regrouping of the expenses will have to be operated depending on the purpose of the study: *the perspective of the made decision, the perspective of the management through budgetary abatements or the perspective of the hospital structures financing.*

III. Evaluation instruments. The experts in the health department are more and more preoccupied by issues such as: *Is it necessary to launch a breast-cancer detection program? Should laparoscopic surgical interventions be preferred over classical interventions? What type of anti-asthmatic treatment must be planned and for what type of disease? For what kind of surgical intervention should be established a smaller number of hospitalization days*?. The answer to all these questions can be given once we have the evaluations of the rapports cost-results of various

health programs that presuppose, in fact, three types of interventions: *cost measurement, result measurement and the combination of the two elements.* The proposed endeavor is rather heavy because in the health-care field, the lack of market price raises serious problems in cost evaluation. At the same time, in the absence of economical aspects, it is difficult to express measure and regroup the patient's preferences.

IV. The temporal horizon. The medico – economic studies generally analyze the health programs whose costs or consequences extend over a longer period of time. Time intervenes both on the *level of accomplishments (for instanced the long term treatments that require long life equipments)* and at the *level of the consequences (avoiding a disease for a long time*). Due to this fact, if we wish to compare the different periods of time, it is important to account them in the same measuring unit, technique called *actualization, which takes into consideration the population's preference who benefits from the health-care programs in the present, which will be paid for later on, in the future.* Health, regarded as a non-transferable good in time that doesn't belong to the market, raises the following issues, in the actualization domain: *What actualization rate should be employed? Are we actualizing only the costs or the results, as well? In case of a positive answer, is the actualization rate the same?*

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