



Why you need to market your GP practice

By Dr Michael Taylor, National Chairman

Covering:

The end of the GP monopoly

Patient dissatisfaction

Polyclinics and the poaching of patients

Coping with the loss of patients

How do you know if you need to market your practice?

It's very simple. If you have anxiety about the shifting culture of general practice it is likely that you do. If you have any worries at all about losing patients to nearby practices, then, if you wish to survive comfortably, it is certain that you will have to market your practice effectively. If you are not even that little bit scared then it suggests you do not properly understand your current predicament.

“Ten million UK citizens are dissatisfied with access to general practice.”

Approaching ten million UK citizens are dissatisfied with access to general practice. In practices we prefer to remember the 84% of the population who are satisfied. Our government takes a different view. The Prime Minister Gordon Brown is reported in the Times of Friday the 14th of December 2007 as saying of health service reforms “the next stage is to combine the diversity of supply with greater attention to diversity in demand; in other words services which meet the need of the individual citizen.” It is important for the sceptics amongst us to remember that the dissatisfaction with access to general practice was

greatest in young people in full time work, the self same group who attend walk in centres. On the one hand it can be argued that these people are the healthiest demographic group in the land, but on the other it can be argued with equal fervour that these are the citizens who through their taxes pay for the National Health Service (NHS) and therefore should have convenience of access just as great as any other demographic group.

So, Number 10 Downing Street, and therefore the Department of Health (DH), the Strategic Health Authorities (SHAs), and the Primary Care Trusts (PCTs) are all keen for practices to be responsive to patient need and desire especially with regards to in-hours access and extended hours convenience. This keenness is not some flavour of the month but a serious political imperative; the government is intent on having its way; we GPs are deaf at our peril.

Though I am not privy to the conversations in Number 10, nor in Richmond House on Whitehall, I can understand that it is not in the interests of the modernisers of Public Services, that GP's are effectively a monopoly provider of GP services. So this monopoly will be challenged and will be broken. This process of change to have a plurality of provider has already begun. “Entrepreneurial” GPs have managed to take over practices, Chilvers McRae already have more than twenty practices in their possession and are hungry for more. Other practices have taken over nearby practices, and out of hours providers are muscling in on the act. None of this has yet had any dramatic effect upon most of us so is there any need to be concerned?

The DH is keen to have most secondary care trusts gain autonomy as Foundation Trusts. It is highly likely that some if not most of these will develop a primary care service once the appropriate legislation is in place. This will now be so much easier as there is a growing surplus of GPs. Though some High Street providers of services would like to be players they are currently a little reluctant to become directly involved in employing GPs. This is partly because in the case of Boots they got their fingers burned with Boots Dental Services, partly the difficulty that PCTs had in directly running GP practices and partly because normal commercial rules do not apply in the NHS. In the Channel Isles, however, it is already pharmacies employing GPs that provide the islands' primary care services. Providers of health services from outside the UK do know how to do the job and they are waiting in the wings. Currently these are Health Maintenance Organisations from the USA, and health care providers from South Africa.

Let me return to the 84% of UK citizens who are “satisfied” with access to their GP services as determined by the IPSOS MORI questionnaires. This 84% is a merger of “completely satisfied”, “very satisfied” and the greater number of “satisfied”.

The realities of our new competitors

Your competitors will not be interested in the completely and very satisfied, but in the satisfied and dissatisfied they will see their potential customer; these last two groups could therefore total 60% or more of the total population! So for the average UK practice 40% of patients can be thought of as loyal while 60% we have to work to retain.

To make matters more concrete, let me use my practice as an illustration. I practise in a town of 30,000 citizens, and mine is one of five practices, three small, one large and one middle-sized. We are a part of a PCT in an area of deprivation and are deemed to be under doctored. The PCT is to have four new Darzi practices and slightly later a Darzi clinic. One of the new Darzi practices will be located in our small town! This worries me.

The new practice which will be well funded is expected to attract 6,000 patients over the five years of its contract. Effectively this means that it will look to attract 20% of the town's population. The new practice will have a boundary co-terminus with the PCTs. This describes a practice area much greater than my practice area. (How the new practice will arrange to manage home visits at such distances we wait to see. Maybe the Darzi review due in July of this year will modify the regulations with respect to home visits). However, having the practice area larger could mean that this new practice could attract patients from nearby towns, but then similarly the Darzi practices in the nearby towns can attract patients from our town. These two effects are therefore self-cancelling. So for the ease of understanding and calculation we are back to the frightening notion that the new practice will be looking to attract 20% of our town's population or more pertinently 20% of patients from each and every practice in town.

As you may imagine I have expressed an interest to the PCT to acquire the contract for the new practice. I have now received the guidance and developing questions for the next stage in the application; this is the "PQQ" or Pre Qualification Questionnaire. One of the questions is this one; "What is your marketing plan?" If the PCT and therefore the SHA and therefore the DH think that marketing is essential for the new practice I would be foolish in the extreme to ignore or dismiss marketing's importance. What is more, I am informed that there are more than 20 expressions of interest. One of them is from a nearby Foundation Trust; others are from GP colleagues and commercial interests. Some competitors have large budgets, some have commercial savvy; what worries me is that a few have both!

Currently very few GP practice compete openly with others; the number is negligible. However with the establishment of the 150 Darzi Clinics situated in areas of high population density, I suspect the rather gentlemanly culture will change if not overnight, then within the first few years of operation. The struggle to retain practice numbers of patients will have a ripple effect which will be felt for a few miles. It is quite possible that the introduction of 150 new clinics will have an impact on the culture of general practice out of proportion to the resources involved. If it doesn't, then other coercive stimuli will be designed to force GP practices to be more responsive.

"The struggle to retain practice numbers of patients will have a ripple effect..."

Imagine your practice is very close to a new surgery or clinic of a new provider, how will you cope with the loss of patients? The closer the new clinic is to your practice the greater is the risk of loss of both patients and income. If you are pram-pushing close the threat and danger is not only real but great.

In the next issue I will look at the basics of marketing so that you can plan your fight back or even get your retaliation in first.



Dr Michael Taylor, National Chairman

Dr Michael Taylor graduated from Edinburgh University and has worked in various high profile treatment and diagnostic faculties. It was his firm belief that patients are more important than their diseases that led him to join the Small Practices Association 15 years ago.

His conviction and passion for the medical professional makes him a pivotal part of the Family Doctor Association, which he is determined to make an essential part of the medical profession's future

If you'd like more information about the work of the Family Doctor Association or want to become a member, please visit our website at www.family-doctor.org.uk, email us at admin@family-doctor.org.uk or call our national office on **01706 620 920**.



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